

This report is dedicated to the memory of Caitlin Wright Binning

an impassioned advocate for people with mental illness

Caitlin Wright Binning, a member the Northern Virginia Regional Planning Partnership representing the Northern Virginia Mental Health Consumers Association, passed away on July 25, 2003.

Caitlin was a tireless, fearless and effective advocate for Virginians with mental illness and their families. She was instrumental in reforming the mental health system, and especially the quality of care in Virginia psychiatric hospitals.

"In my 30 years working in the field of mental health, I have seen few people show the level of dedication to patients and the personal integrity that Caitlin exhibited. She went way beyond acceptable limits. Watching her work always gave me a sense of hope, and I know that others got the same message. Caitlin reminded me of the reason I went into mental health care in the first place. I am going to miss getting that sense from her."

William M. Glazer, M.D. Associate Clinical Professor of Psychiatry Harvard Medical School Massachusetts General Hospital

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OUR VISION FOR MENTAL HEALTH SERVICES:

Development of a cost-effective, comprehensive, culturally competent array of recovery oriented, consumer choice driven integrated services that are flexible and accessible to consumers and oriented toward proactive care, maintaining stability, and maximizing independence and community integration. Education must be intensified to combat and overcome discrimination historically associated with mental illness.

EXECUTIVE SUMMARY

Commissioner James Reinhard, M.D., Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services, initiated a planning process to explore opportunities with all interested stakeholders to achieve a true community-based system of care. In December 2002, the Northern Virginia Regional Partnership Planning Project began, co-chaired by James A. Thur, Executive Director of the Fairfax-Falls Church Community Services Board (CSB), and Lynn DeLacy, Director of the Northern Virginia Mental Health Institute (NVMHI). A broad representation of stakeholders, including Board chairs and staff from the five Northern Virginia CSBs, directors and staff of two State facilities [NVMHI and Northern Virginia Training Center (NVTC)], advocates from each of the service areas, consumers, and providers from the private sector, are participating in this planning project.

The Steering Committee for the Northern Virginia Planning Process determined that it would focus on adult mental health services with a special emphasis on persons with serious mental illness. Several work groups were established to focus intensively on specific issues. These groups include the Mental Health Work Group, which addressed hospitalization utilization, forensics and NGRI (Not Guilty by Reason of Insanity status), co-occurring mental illness/substance abuse disorders, and other related issues. The Structural Work Group reviewed the overall structure that supports mental health services in Northern Virginia, while a Private Hospital Work Group met to discuss issues common to both public and private psychiatric hospital services. Two other groups that were already in existence contributed to the process, as well: one elaborated on issues facing older adults with mental illness or with dementia. The other addressed co-occurring mental retardation/mental illness issues.

One of the first tasks facing the Steering Committee was to develop a vision statement and guiding principles, emphasizing the use of the Recovery Model in service planning and practice. Once completed, the statement and principles were used to guide the planning process.

The outcomes of this process lend themselves to improving mental health services in the region. Among the more notable achievements are the following:

- 1 The Mental Health Work Group collected and analyzed data to describe trends and to support planning recommendations.
- 2 Northern Virginia Mental Health Institute created an instrument to describe the levels of treatment needed by patients in public and private hospitals serving Northern Virginia. Both public and private providers of inpatient psychiatric services then applied this instrument.
- 3 The co-chairs of the Planning Process facilitated a dialogue among public and private sector inpatient hospital providers.
- 4 As a result of this planning process, the Steering Committee developed a plan to transfer about \$2.5 million in State funds from NVMHI to CSBs.
- 5 The process improved coordination and communication among public and private providers.
- 6 The Steering Committee made evident that the number of persons with no health insurance or inadequate coverage for psychiatric care is increasing.
 - Many indigent people are ineligible for Medicaid because of Virginia's restrictive eligibility.
 - Most of the 28% of persons who are uninsured are treated as charity care by private hospitals.
- 7 Following discussion of employment needs of persons with serious mental illness, the Steering Committee endorsed a federal WorkFORCE grant application submitted by vaACCSES in collaboration with several state and regional agencies.
- 8 Led by the Structural Work Group, the Steering Committee and its other work groups identified statewide policies issues that include three recommendations for Statelevel actions:
 - A. Addressing several forensic/NGRI issues
 - B. Supporting ongoing consumer empowerment training
 - C. Implementing a Consumer and Family Affairs Office
- 9 In preparation for the continuation of this process, the work groups identified the following issues to be considered in the next planning phase:
 - A. Service Issues
 - 1. Recovery Model
 - 2. Move patients from institutions to community re: Olmstead
 - 3. Greater emphasis on employment services
 - 4. Services appropriate to settings, e.g., nursing home, jails, shelters
 - 5. PACT teams
 - 6. Availability of medications across the region
 - 7. Pharmacies
 - 8. Psychiatrists and nurses for medication clinics
 - 9. Resource gaps, especially residential, day programming and possibly in-home services
 - B. Service Populations
 - 1. Youth and Families
 - 2. Persons with co-occurring mental illness and substance abuse
 - 3. Persons with co-occurring mental retardation and mental illness

- C. Forensics
 - 1. Use of earmarked funds for NGRI
 - 2. Community education re: use of Western State Hospital Forensics Unit
 - 3. Forensics population data
- D. Hospital Issues
 - 1. Use of private psychiatric hospital beds
 - 2. Differential utilization of Private Bed Purchase (PBP) by CSBs
 - 3. Random nature of monthly demand for PBP
- E. Funding Issues
 - 1. Reinvestment funds
 - a. Diversion strategies and services
 - b. Discharge strategies and services
 - 2. Incentives and disincentives
 - 3. Per capita expenditures
 - 4. WorkFORCE Action Grant Initiative
- F. Consumer Issues
 - 1. Consumer Empowerment and Leadership Training (Mental Health Association of Virginia)
 - 2. Family education
 - 3. Consumer-directed services
- 10 The Steering Committee has concluded that no beds should be closed at NVMHI at this time. This recommendation is based on anticipated population growth through 2010 and the proposed reduction in private sector psychiatric beds for adults in Northern Virginia.

BACKGROUND

At the direction of James Reinhard, M.D., Commissioner of the Department of Mental Health, Mental Retardation, and Substance Abuse Services, a process was initiated in each region of the Commonwealth to explore opportunities with all interested stakeholders to achieve a true community-based system of care.

The Northern Virginia Regional Partnership Planning Project began on December 19, 2002, with the first meeting of the Steering Committee, co-chaired by James A. Thur, Executive Director of the Fairfax-Falls Church Community Services Board (CSB), and Lynn DeLacy, Director of the Northern Virginia Mental Health Institute (NVMHI). A broad representation of stakeholders, including Board chairs and staff from the five Northern Virginia CSBs, directors and staff of two State facilities [NVMHI and Northern Virginia Training Center (NVTC)], advocates from each of the service areas, consumers, and providers from the private sector, are participating in this planning project.

This is a long-term, strategic process that requires a comprehensive assessment of the current system of care. This process encompasses on-going, regionally-based planning; communicating with key stakeholders; engaging in a dialogue about major issues facing the region; proposing regional and state-level actions that would improve the quality of care and service capacity in the region; and exploring opportunities to restructure the region's public mental health service delivery system.

PLANNING PROCESS

One of the first tasks facing the Steering Committee was to develop a vision statement and guiding principles, emphasizing the use of the Recovery Model in service planning and practice. Once completed, the statement and principles, as detailed in Appendix A, were used to guide the planning process. Simultaneously, the Steering Committee created a number of small work groups tasked with studying particular areas of interest and making recommendations for short-term system practices and long-term policy issues. To solicit input from all community stakeholders, fourteen public forums and consumer focus groups were held throughout the region and are summarized in Appendix B.

While the Steering Committee recognized service needs in special populations such as children, youth and older adults, it selected mental health services for adults as the initial focus for review. This population is most likely to be impacted by the trends toward fewer private psychiatric hospital beds and continual population growth. To address this issue, the Steering Committee formed a Mental Health Work Group (MHWG), comprised of CSB mental health program managers, facility staff, private providers, advocates and consumers. The MHWG was tasked with describing both current and projected service capacities, utilization patterns, and gaps in the service continuum. In addition, they were asked to make recommendations for short-term adjustments in the current service system and long-term policy changes that would improve the quality of services for adults with serious mental illness. The group met at

least monthly and contracted with a consultant who assumed responsibility of analyzing several data sets and drafting this report.

As it set out to address the issues posed to it, the MHWG identified a need for a descriptive tool that it could use to illustrate the different service needs of patients in need of psychiatric inpatient care. The NVMHI developed and the MHWG adopted the "Levels of Adult Inpatient Treatment" model, describing four types of inpatient treatment. This model was applied to the patient population at NVMHI, Western State Hospital (WSH) and inpatient private psychiatric hospitals in order to begin to explore inpatient service delivery in the region.

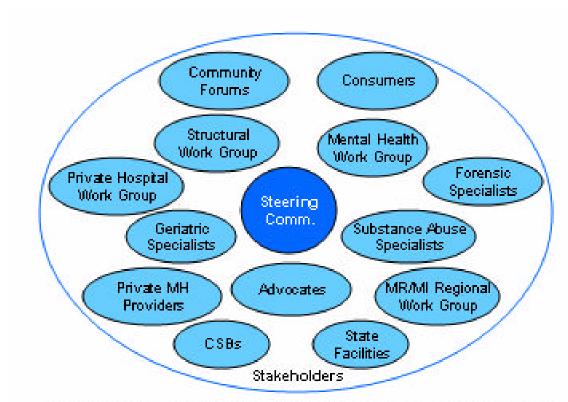
The Steering Committee also formed the Structural Work Group to review the overall structure that supports the regional service system. Specifically, the Structural Work Group is charged with recommending strategies that the region might use to improve regional and local systems of care. They are also charged with making recommendations for state-level actions that would improve the system of community-based services. Membership on this work group included chairs and executive directors of the five Northern Virginia CSBs, NVMHI and NVTC directors, and consumer representatives.

A third work group began its work in March 2003. Designed to foster and facilitate collaboration between public and private sector psychiatric hospitals, a group was convened that includes representatives from all of the private hospitals in the region that provide psychiatric inpatient services, the executive directors of the five regional CSBs, the NVMHI and NVTC directors, and consumer representatives. They have come together to discuss future plans for public and private psychiatric inpatient care. Meeting monthly since March, this group has described the current psychiatric bed capacity in the private sector, applied the "Levels of Adult Inpatient Treatment" model in order to develop a profile of patients served in the private inpatient units, and identified potential systems barriers that may impact inpatient services. The group has been instrumental in enhancing communication across the public/private service continuum and enhancing the working relationships among the private hospitals and the CSBs. Most recently, discussions have begun with community-based private providers to more fully integrate them into the MHWG.

Two groups established prior to this planning activity have been instrumental in this process. The Northern Virginia Regional Mental Retardation/Mental Illness Workgroup and the Regional Geriatric Services Program Directors from the five CSBs each have contributed information and recommendations related to the special populations that they represent.

As shown in Figure 1, many people contributed their perspectives to this planning process. Membership lists for these work groups are included in Appendix C.

Figure 1



Participants in the Northern Virginia Regional Partnership Planning Project

NEEDS OF INDIVIDUALS IN THE REGION AND IMPLICATIONS OF CURRENT DATA AND TRENDS

A large and diverse body of data was collected and analyzed in order to support the planning effort as a data-driven exercise. In addition to the data presented here, supplemental data may be found in Appendix D. Below is a summary of the primary conclusions that were drawn from the data that were analyzed.

Population Trends for the Northern Virginia Area

- Northern Virginia's population is growing more than twice as fast as the rest of the Commonwealth. The Council of Governments projects that the regional population will increase by more than 20 percent this decade to 2,181,000 in 2010.
 - o The Northern Virginia population, which has been growing by 300,000 per decade for the past half century, is projected to increase by 365,000 this decade and by almost another 300,000 between 2010 and 2020.
- The Northern Virginia population has rapidly become extraordinarily diverse. In 1970, less that 10 percent of Northern Virginians were racial or ethnic minorities. In 2000, more than 35 percent of Northern Virginians were minorities. The 2000 Census revealed that more than 21 percent of Northern Virginians are immigrants who were foreign-born.
- According to the 2000 Census, the regional poverty rate was 5%, ranging from 2.8% in Loudoun County to 8.9% in Alexandria.
 - o The percent of the population below 200% of poverty was 13.6%, with a low of 7.8% in Loudoun to a high of 21.8% in Alexandria.
 - o 28 percent of psychiatric and substance abuse patients were uninsured in 2002.

Utilization of Public and Private Adult Mental Health Inpatient Hospital Beds

- Admissions are increasing; beds in the public hospitals are either full or at near capacity.
- Private hospitals show lower utilization rates.
- Virginia's financial crisis may increase pressure to reduce the bed capacity of State psychiatric facilities at a time when they are already operating at full capacity and turning away voluntary patients.
- As a result of reductions in State and local funding for FY 2003, the Community Services Boards of Northern Virginia have lost \$6.4 million in funding for mental health, mental retardation and substance abuse services. A reduction of this magnitude in community-based care and treatment will likely increase the demand for inpatient care.
- The two regional facilities, NVMHI and the NVTC, have each absorbed 19% in budget cuts over the past two fiscal years. This represents a loss of \$1.3 million for NVMHI and \$1.1 million for NVTC.
- NVMHI's ability to serve patients with complex needs is limited by the numbers of hospitalized individuals who could be served in the community if expanded services existed.
- At any given time over the past year, an average of 17 NVMHI patients (13%) were on the "Extraordinary Barriers to Discharge List." The annual cost to NVMHI to keep these patients hospitalized instead of discharged for community care is \$3.2 million.

Northern Virginia Utilization Rates at State Hospitals

 Northern Virginia continues to have the lowest bed day utilization rate in the State, estimated at 2,296/100,000 persons.

Capacity and Census at NVMHI

- NVMHI has 127 licensed beds.
- Average FY 2003 daily census was 122 persons
- Occupancy rate is approximately 95%

Discharge and Diversion (DAD) Project - Private Bed Hospitalization Purchase (PBP)

	FY 2001	FY 2002	FY 2003
Total Number Patients	421	333	364
Bed Days	2,773	2,049	2,023
Average Length of			
Stay	6.6 days	6.2 days	5.6 days
Average Number of			
Patients Per Month	35.1	27.8	30.3

- The number of patients needing DAD/PBP funding for hospitalization fluctuate from year to year. Fewer patients used DAD/PBP funds in FY 2002 and FY 2003 than in FY 2001.
- The number of bed days used decreased from FY 2001 to FY 2003.
- Similarly, the length of stay decreased from FY 2001 to FY 2003.
- The number of patients per month varies.
- The FY 2004 average cost per bed ranges between \$550 and \$655/day.

Bed Day Usage NVMHI Plus Diversion and Discharge (DAD)/Private Bed Purchase (PBP)

Admissions:

	FY 2001	FY 2002	FY 2003
NVMHI	418	435	457
DAD/Private Bed	421	333	364
Purchase			
Total	839	768	821

Bed Days:

	FY 2001	FY 2002	FY 2003
NVMHI	43,384	43,549	43,777
DAD/Private Bed Purchase	2,773	2,049	2,023
Total	46,157	45,598	45,800

Average Length of Stay at Discharge (days):

	FY 2001	FY 2002	FY 2003
NVMHI	91	83	125
DAD/Private Bed	6.6	6.2	5.6
Purchase			

- Admissions for NVMHI and Discharge and Diversion (DAD)/Private Bed Purchase (PBP) increased compared with last year:
 - 457 (22 more) NVMHI admissions in FY 2003 compared with 435 in FY 2002
 - 364 (31 more) DAD/PBP admissions in FY 2003 compared to 333 in FY 2002
 - Together 821persons were admitted for psychiatric care.
- Similarly, the number of bed days used at NVMHI is continuing to increase, from 43,384 in FY 2001 to and estimated 43,777 in FY 2003.
- DAD/PBP bed days decreased once again from a high of 2,773 in FY 2001 to 2,023 in FY 2003
- During FY 2003, 14% of patients hospitalized through DAD/PBP were transferred to NVMHI.
- Length of stay is up at NVMHI (125 days) and down for DAD/PBP (5.56)
- The NVMHI FY statistics cannot be compared year-to-year because they reflect discharges of both short and long term patients. In FY 03 NVMHI discharged a larger number of long term patients which makes the length of stay higher than in previous years.
- The length of stay at NVMHI is also reflective of the higher level of complexity of patient needs, patients on NGRI status and the need to expand community capacity.
- Eight of the nine private hospitals are participating in the PBP.

Levels of Adult Inpatient Treatment - NVMHI, WSH, Private Sector

	Average Adult Census	<u>Acute</u> <u>Stabilization</u> High Acuity,	<u>Intensive</u> <u>Care</u> High Acuity,	<u>Intermediate</u> <u>Care</u> Variable Acuity	<u>Rehabilitative</u> <u>Services</u> Low Acuity
	During	Low	High	High	High
	Survey	Complexity	Complexity	Complexity	Complexity
	Days	Exp. LOS =	Exp. LOS =	Exp. LOS =	Exp. LOS =
		2-5 days	< 30 days	> 30 days	> 30 days
Public Hospital					
NVMHI*	126	3 (2%)	15 (12%)	50.5 (40%)	57.5 (46%)
WSH**	32	4 (12%)	4 (12%)	13 (41%)	11 (34%)
Total for Public Hospitals	158	7 (4%)	19 (12%)	63.5 (40%)	68.5 (44%)
Private Hospital					
Dominion*	19	1.5 (8%)	13 (65%)	5 (25%)	0%
Inova					
Alexandria*	12	8.5 (71%)	3.5 (29%)	0%	0%
Inova Fairfax*	28	12.5 (45%)	10.5 (38%)	4.5 (16%)	<1 (1%)
Inova Mt.					
Vernon**	19	5 (26%)	5 (26%)	7 (37%)	2 (11%)
Loudoun**	11	3 (27%)	5 (46%)	0%	3 (27%)
Northern Virginia					
Community*	13	2.5 (19%)	8 (62%)	2.5 (19%)	0%
Potomac**	6	4 (67%)	2 (33%)	0%	0%
Prince William**	20	15 (75%)	5 (25%)	0%	0%
Virginia Hospital					
Center***	16	10.5 (66%)	5.5 (34%)	0%	0%
Total for					
Private	144	62.5 (43%)	57.5 (40%)	19.0 (13%)	5.0 (4%)
Hospitals					

^{*} Based on average census over two days.

- A survey, based on the "Levels of Adult Inpatient Treatment" model (Appendix E) was conducted at the NVMHI, WSH and the nine private hospitals in the Northern Virginia region. The results show that:
 - The public sector currently provides care mainly for long-term patients who need intermediate care or rehabilitative services, whose acuity is low or variable, but whose service issues are complex. Some of these patients could be treated in the community if service capacity were expanded.
 - The private sector currently provides care primarily for patients who need short-term, acute stabilization or intensive care, whose acuity is high, and who service issues vary from low to high complexity. However, the private sector is challenged to manage some patients requiring intensive care.

Complexity and Specialized Needs of NVMHI Adult Mental Health Patients

A survey conducted for 123 patients at NVMHI during a 48 hour period in June 2003 shows that:

^{**} Based on one-day census.

^{***} Based on 5-day average census.

- 16% did not have English as their primary language.
 - For 9% this presented a barrier to treatment.
- 43% of the patients usually adhere to medication regime while in the hospital.
- o 50% have co-occurring diagnoses, e.g., MH/SA, MH/MR, MH/SA/MR
- o 46% have a chronic co-occurring medical condition.
- o 10% are likely to be physically aggressive.
- 68% were verbally aggressive or have a past history of physical aggression.
- The nine private hospitals in the Northern Virginia region plan to conduct a similar survey in the near future.

Forensics and Not Guilty By Reason of Insanity Inpatient Utilization at NVMHI

- In June 2003, of the 32 of the 33 Forensic/NGRI patients at NVMHI, were of NGRI status.
- On the average, NGRI patients, whose length of stay can range from 3-5 years, occupy almost a quarter of all beds at NVMHI.
- Both new admissions and total number of Northern Virginia Forensic and NGRI patients continue to increase.
- The graduated NGRI community reintegration process and lack of continuum of services in the community negatively impacts the length of stay for NGRI patients at NVMHI.
- Community reintegration is slowed for a number of these patients due to a lack of housing and concern about community risk.

Community Residences

	Resi Overnight	Ily Intensive esidential: ght Awake Care, sive Treatment Group Home or Halfway House		dential: Care, Less Freatment in Home or	Supervised Residential: Overnight Care, Less Intensive Treatment in Supervised Apartments or Domiciliary Care		Supported Residential: Unstructured Services in Individuals Own Housing Arrangement	
	Direct		Direct		Direct		Direct	
CSB	Run	Contract*	Run	Contract	Run	Contract	Run	Contract
Alexandria	0	1	22	0	78	0	34	0
Arlington	0	3	0	14	0	25	20	169
Fairfax-Falls								
Church	14	8	16	16	140	22	178	78
Loudoun	4	1	10	0	16	0	46	0
Prince William	0	3	0	0	54	0	83	0
Subtotal	18	16	48	30	288	47	361	247
Total	34	(3%)	78 (7%)		335	(32%)	608	(58%)

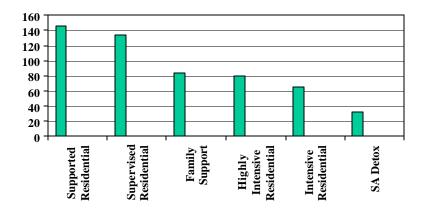
^{*} The allocation of these regional program beds is based on FY 2003 utilization.

 Northern Virginia has a combined capacity of 447 in residential facilities and supports another 608 persons in their own residences.

Unmet Needs

- The DMHMRSAS Comprehensive Plan point-in-time survey documented extensive unmet needs.
- Significant wait lists exist for services that prevent hospitalization and those that facilitate hospital discharges, such as medication management, assertive community treatment, rehabilitation services, residential services and family support. (See wait list data in Figures 2 and 3 and in Appendix D.)
- Approximately 75% of the NVMHI patients at Level IV (Rehabilitative Services) could be served in the community with expanded community-based services.
- Many persons with mental illness are unnecessarily incarcerated in local jails. For example, a recent estimate at the Fairfax County Adult Detention Center suggests that of 1,100 inmates, about 200 are persons with serious mental illness and/or substance abuse problems.

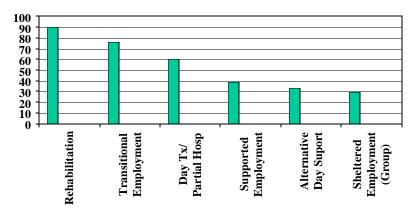
Figure 2: Northern Virginia CSBs' Wait List for Residential Services



Source: Regional Submission to DMHMRSAS Comprehensive Plan 2004-2010

 While many people are waiting for residential services, almost 300 individuals need the less intensive types of residential supports.

Figure 3: Northern Virginia CSBs' Wait List for Day Support Services



Source: Regional Submission to DMHMRSAS Comprehensive Plan 2004-2010

 Topping the list of day support services are rehabilitation and transitional employment.

Uninsured in Northern Virginia

- The Virginia Health Care Foundation survey (December 2000/January 2001) indicates that 11% of Northern Virginians are uninsured.
- Increases in the proportion of Northern Virginia hospital patients who are uninsured suggests that the rate is at least 12% -13% now, equating to about 250,000 uninsured persons in the region.
- If the number of immigrants continues to increase in Northern Virginia, there will be a commensurate increase in the uninsured population.

Charity Care

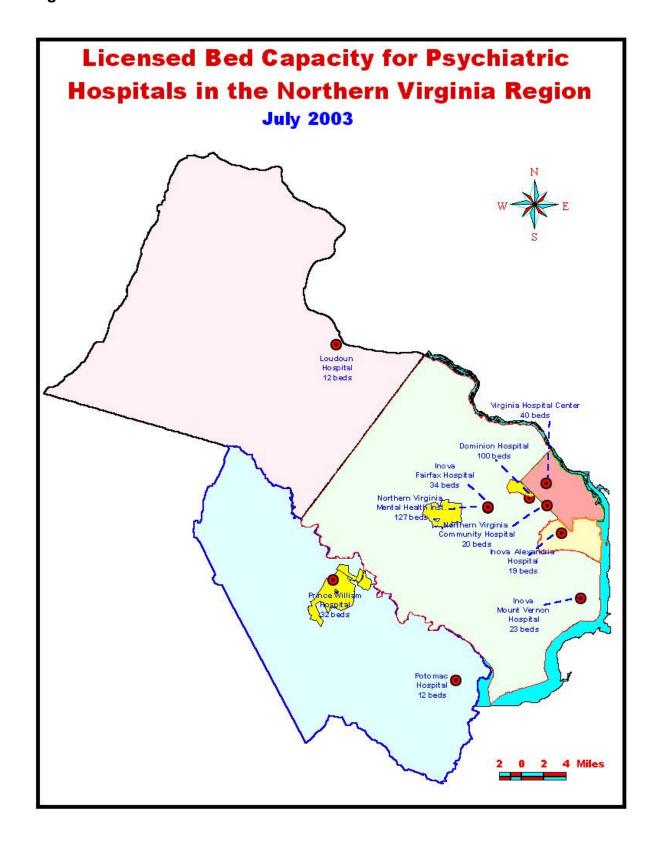
- A large and increasing percentage of the psychiatric and substance abuse patients served in the private hospitals do not have insurance coverage for their hospitalization.
- In 2002,
 - 28% of psychiatric and substance abuse patients were uninsured for the services provided,
 - 13% were covered by Medicare
 - 6%were Medicaid patients
 - 7% were covered by other State or local programs

- 1% had reimbursement provided by the military system.
- Less than half of patients (45%) had private insurance coverage.
- The proportion of private hospital psychiatric patients without insurance coverage is more than twice the regional percentage of the population that is uninsured because adults with mental illness are more likely to be uninsured and because some persons have health insurance that does not cover all psychiatric hospitalizations.
- The number of persons with no health insurance or inadequate coverage for psychiatric care is increasing. In addition, many people -- although indigent -are ineligible for Medicaid because of Virginia's restrictive eligibility.
- Charity care is medical care provided free of charge to low and moderate income uninsured individuals, with hospitals or other providers not seeking payment for services rendered. Although some uninsured individuals have the means to pay out-of-pocket for part or all of the inpatient psychiatric care rendered, it is likely that most of the 28% who are uninsured are treated as charity care by the private hospitals. The large charity care levels, combined with a relatively low percentage of persons who are privately insured, place significant strains on the financial operations of private hospital psychiatric services.

Psychiatric Bed Capacity at Private Hospitals

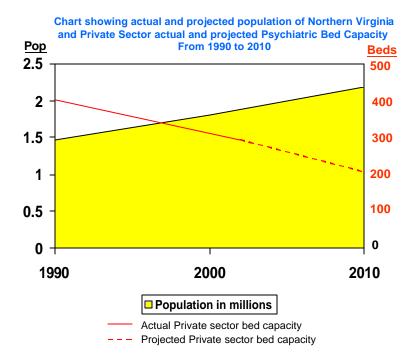
- The number of psychiatric and substance abuse hospital beds in private facilities in Northern Virginia increased substantially in the 1970s and 1980s as general community hospitals established units, freestanding psychiatric hospitals were created, and both added beds to existing units. Since 1990, the number of such beds has decreased from 402 to 292. This reduction has occurred through the conversion (and program reduction) of a 71-bed freestanding psychiatric hospital to a residential treatment facility and the closure or consolidation (with bed reduction) of substance abuse programs into psychiatric units. No hospital has significantly more beds now than in 1990.
- The first significant expansion of psychiatric capacity in many years is planned with a 10-bed expansion of a community hospital psychiatric unit at Loudoun Hospital. That expansion has been supported by both the regional health planning agency and State Health Department staff, with final action expected within weeks.
- Eight of the ten general community hospitals have psychiatric units (ranging in size from 12 to 40 beds), and there is one freestanding private psychiatric hospital with 100 beds. The location of these hospitals is shown on Figure 4.
 - Some private hospitals, however, have reported financial losses (operating losses) in their psychiatric units.
 - A Certificate of Public Need application that has been submitted would reduce psychiatric beds by 80 and eliminate two adult inpatient psychiatric units.

Figure 4



HCA has proposed closing both Dominion Hospital and Northern Virginia Community Hospital and transferring the approved bed capacity to Loudoun County by 2005 for use as general hospital beds. This will result in the loss of 80 adult psychiatric beds. This may create a shortage of psychiatric beds for adults throughout the region.

The trend is best displayed graphically in Figure 5.



Because of the time required to make adjustments in the location and size of psychiatric units, it is recommended that the proper time frame for planning would be 2005 to 2010.

Location of Licensed Hospital Psychiatric Beds

- As shown in Figure 4, most of the licensed inpatient hospital beds are in the eastern section of Northern Virginia.
- However, most of the new population growth is in the western section.
- Travel time is much slower than the distances on the map suggest.
- There are proposals to close beds in the eastern section but not to open psychiatric beds in the western section.

Use of Private Hospital Units

- The average daily census in private hospital psychiatric and substance abuse units has decreased from 321 in 1990 to 167 in 2001. Data from some but not all hospitals show further decreases since 2001.
- Private psychiatric hospitals in Northern Virginia reported a bed utilization rate of about 60% in 2001.

Private Hospital Patients According to Age and Diagnosis

- In fiscal year 2002 (July 2001 through June 2002) the average daily census of patients with a primary psychiatric or substance abuse diagnosis was 173. (This is larger than the number of patients in psychiatric units because a small number of patients with psychiatric diagnoses are treated in medical units.)
- This average census of 173 patients includes 152 with a primary psychiatric diagnosis and 21 with a primary substance abuse diagnosis.
- Of the 173 patients on an average day:
 - 31 were under the age of 18 (90% of those were at one facility with a substantial child and adolescent program)
 - o 119 patients were between the ages of 18 and 64.
 - o 23 were over the age of 64.

REGIONAL PARTNERSHIP STATUS REPORT

Mental Health Work Group

The Mental Health Work Group (MHWG) is tasked by the Steering Committee to describe both current and projected service capacities, utilization patterns, and gaps in the service continuum. In addition, they are asked to make recommendations for short-term adjustments in the current service system and long-term policy changes that would improve the quality of services for adults with serious mental illness. This large group is comprised of representatives from the CSBs and facilities, private providers, consumers and advocates. They meet monthly and sometimes more frequently to openly discuss issues, evaluate data pertaining to specific mental health issues, and suggest ways in which services may be improved. This is a highly collaborative effort modeled after a similar process that the CSB and NVMHI discharge planners have used successfully for several years.

The MHWG contracted with a consultant who assists them by collecting, analyzing and interpreting statistical data related to mental health consumers and services and by drafting this report. The data presented in this report is a product of the MHWG's efforts to make recommendations supported by statistics as well as by experience and expertise of the Work Group members.

The MHWG elected to handle some special interests within its own work group, while capitalizing on the work of other groups for other issues. The issues for two special groups of people are being addressed directly within the MHWG: for persons who have mental illness and are forensic patients and for other individuals who have mental illness and substance abuse problems.

On the other hand, the MHWG recognizes the benefit of having many people work on special issues. They have collaborated with two existing work groups, one for older adults with mental illness or dementia and another for persons who have both mental retardation and mental illness. Reports from these two groups are included as appendices to this report.

Recovery Model

Early on, the MHWG adopted the Recovery Model as the philosophical underpinning for its reviews and recommendations. The Recovery Model, explained more fully in Appendix F, is based on the premises that:

- A holistic view of mental illness focuses on the person, not just the symptoms.
- Recovery is not a function of one's theory about the causes of mental illness.
- Recovery from severe psychiatric disabilities is achievable.
- Recovery can occur even though symptoms may reoccur.
 - o individuals are responsible for the solution, not the problem.
 - o recovery requires a well-organized support system that incorporates
 - o consumer rights, advocacy, and social change
 - o applications and adaptations to issues of human diversity.

Levels of Adult Inpatient Treatment

As it set out to address the issues posed to it, the MHWG identified a need for a descriptive model that could be used to illustrate the different service needs of patients requiring psychiatric inpatient care. NVMHI participants developed a model describing four levels of inpatient treatment that was subsequently adopted by the MHWG.

- The multi-variant model categorizes patients' treatment levels according to acuity, complexity and expected length of stay. This model was applied to patient populations at NVMHI, WSH and private hospitals in order to determine the percentage of patients receiving each level of treatment at each facility. The findings of the "Levels of Adult Inpatient Treatment" survey are discussed earlier in this report and suggest that:
- The public sector hospitals presently provide care mainly for patients who need intermediate care or rehabilitative services, whose acuity is low or variable, whose complexity is high and who need more than 30 days of inpatient service.
- The private sector hospitals care primarily for patients who need acute stabilization or intensive care, whose acuity is high, with low or high complexity and who need less than 30 days of inpatient service.
- The private sector hospitals are challenged to manage certain patients in Level II (Intensive Care), some of whom are declined admissions to these settings even if they have insurance.
- While NVMHI has expertise to provide Level II Intensive Care, its ability to do so is limited because of the number of hospitalized individuals who could be served in the community if capacity were expanded.
- People with any illness requiring ongoing medication sometimes stop or refuse medications. Private hospitals are particularly challenged to provide psychiatric treatment to persons who refuse medication since they currently do not utilize the process for seeking legally authorized representatives.
- Some private hospitals have been developing special capabilities within their psychiatric units. Inova Mount Vernon, for example, has a more comprehensive service and is not focused on just acute or intensive care and Loudoun Hospital Center has a strong geriatric psychiatric center

Other Issues

The MHWG identified several issues during the course of its work. The following is a list of the issues, many of which have already been discussed in an earlier section that summarized the needs of individuals in the region and discussed implications of the current data and future trends. The MHWG:

- Assessed the availability of hospital beds
- Examined special characteristics of patients hospitalized at NVHMI, in terms of language barriers, co-occurring conditions and other important factors
- Reviewed existing residential services and unmet needs
- Explored the availability of employment and vocational services

- Studied Forensics issues and is planning to invite a speaker to discuss the Arkansas Partnership Program at a MHWG meeting this fall
- Provided a forum for open discussion of pertinent MH issues
- Reviewed data pertaining to public and private hospital usage, services, forensics, comparative levels of inpatient treatment, population and other factors
- Reviewed the trends and recommendations noted in the Access and Alternatives Report
- Examined opportunities to expand the continuum of services for forensics/NGRI patients.
- Examined potential to use crisis beds for both diversion and discharge, i.e., stepdown.
- Examined potential innovations to move patients on the Extraordinary Barriers to Discharge List.

Based on its extensive knowledge of the clinical practices in Northern Virginia, as well as the statistical review it conducted for this report, the MHWG does not recommend any reduction in State facility beds. Northern Virginia has the lowest State facility bed utilization. At the same time, NVMHI occupancy runs about 95%. The Steering Committee conveyed these concerns in a letter sent to the Commissioner on March 18, 2003. (See Appendix G.)

As its next steps, the MHWG intends to:

- Encourage the implementation of the Recovery Model Application at NVMHI and CSBs by identifying a subgroup with diverse participation to identify strategies for a possible regional event as a way to encourage the CSBs and facilities to use the Recovery Model within their programs
- Examine the differential utilization of PBP by jurisdiction
- Explore the random nature of monthly demand for private sector bed purchase
- Study the differential use by jurisdiction of WSH for Forensics patients.

Structural Work Group

The Structural Work Group (SWG) was tasked by the Steering Committee with identifying regional issues and recommending regional solutions. Members of the SWG include the chairs and executive directors of the five Northern Virginia CSBs, the directors of NVMHI and NVTC, and consumer representatives. They considered 14 issues as candidates for possible collaboration and offered recommendations for several of them, as shown in Appendix H. The issues included:

- 1. Information Technology
- 2. Training
- 3. Quality Assurance/Quality Improvement
- 4. Reimbursement Activities
- 5. Center for Excellence

- 6. Cultural Competence
- 7. Evidence Based Practices
- 8. Services for Deaf and Other Specialized Populations
- 9. Prevention
- 10. Regional Approach to Grants
- 11. Collaboration with Various Community Organizations
- 12. Emergency Response/Management
- 13. Maximization of Medicaid Revenue for the Region
- 14. Coordination of Regional Mental Health Issues.

The Structural Work Group will monitor the implementation of recommendations specified in their report.

Private Psychiatric Hospital Work Group

In March, 2003, a Private Psychiatric Hospital Work Group (PPHWG) was formed, consisting of representatives from eight private sector hospitals with a psychiatric unit and one freestanding psychiatric hospital in Northern Virginia. Representatives of the CSBs, MHWG and advocacy organizations joined these members. This group met monthly but also completed special assignments in between meetings.

The most notable achievement of the PPHWG was the application of the "Levels of Adult Inpatient Psychiatric Treatment" model to psychiatric patients at the nine hospitals. The results of this survey are discussed earlier in the statistical section and in the MHWG section.

The PPHWG also reviewed the State's Access and Alternatives Report on several occasions. However, additional time is required to analyze the relevance of the recommendations to Northern Virginia.

During the next phase of the study, the private hospitals have agreed to survey their patients to establish a profile using selected personal characteristics. The results of the survey may be used to impact service delivery. When this information is combined with the results of the "Levels of Adult Inpatient Treatment," it will be possible to clarify the role of public and private providers of inpatient psychiatric services during the period 2005 to 2010. The PPHWG will also review the current pattern for serving the Medicaid population and determine if it is possible to change this pattern to maximize Medicaid revenues.

Private Provider Network

The Northern Virginia region has excellent nonprofit, private providers of mental health services. The network of private providers of residential and day support services is

represented on the Steering Committee. In order to further enhance collaboration with the provider community, the Private Provider representative on the Steering Committee has initiated a series of informational meetings with the provider community. One meeting was held on July 21, 2003 and additional meetings are planned. It should be noted that NVMHI, DRS, community-based private providers, consumer-run centers and DMHMRSAS have collaborated with vaACCSES to develop their federal grant application for regional participation in the Working for Freedom, Opportunity and Real Choice through Community Employment (WORKForce) Action Grant Initiative.

Older Adults with Mental Illness and Persons with Dementia Who Have Psychiatric Symptoms

Although Northern Virginia has the youngest population in Virginia, it also has increasing numbers of older adults in most of the region. The percentage of the population age 65 and over increased from 6.9% (101,323 persons) in 1990 to 7.5% (135,555) in 2000. Further increases are projected for this decade, with larger growth in the elderly population when baby boomers begin reaching age 65 after 2010.

A recent report suggests that the anticipation of the increased costs of care associated with the growing number of older adults in Virginia has led to a gradual process of "defining older persons out" of the existing mental health system of services. This has been done by applying different and more stringent admission criteria at state hospitals than are used for those under age 65; excluding Dementia as a valid diagnosis for admission even if the client meets all criteria for involuntary commitment; assuming that Nursing Homes can provide for acute psychiatric needs when nursing homes are not appropriately staffed; and establishing a Priority Population/SMI criteria that favor those under age 65. If left unaddressed, these problems will compound as the aging population increases in number. The number of older Northern Virginians admitted to Eastern State Hospital, the public inpatient hospital in Williamsburg that serves older adults, is declining, perhaps as a function of the distance from Northern Virginia.

A work group convened prior to this planning process has studied the problems facing this population, documented its findings and presented recommendations in its report, included in Appendix I. Their recommendations include:

- 1. A study to be done by an independent group on the following four issues for older adults with mental illness:
 - Psychiatric hospitalization, both public and private
 - Institutional placement, including nursing homes and assisted living facilities
 - Age appropriate availability of the full range of services offered by community mental health centers, including psychosocial day programming, housing, emergency services and outpatient treatment services, and
 - Private community resources.

- 2. The criteria for Seriously Mentally III and Priority Populations be re-written to be more inclusive of older adults and adults who have behavioral and psychiatric symptoms related to dementing illnesses.
- 3. A pilot program be initiated to develop a coordinated approach for a continuum of care between the following groups: One or two nursing homes, one or two assisted living facilities, a community mental health geriatric program, a community mental health emergency service, a local medical hospital psychiatric unit and a State geriatric psychiatric unit.

An alternative approach has also been presented to the Steering Committee and will be considered by the MHWG. Management of dementia patients is challenging, at best, and proposing to use physical or chemical restraints as a best practice is questionable. Consumers report that placing dementia patients with other patients who have serious mental illness can result in increased physically aggressive events. Another type of specialized placement that may be considered for dementia patients is similar to a practice that occurs in Europe where dementia is treated as a neurological, not a psychiatric, disorder.

Individuals with Co-Occurring Mental Retardation and Mental Illness

The Northern Virginia Regional Dual Diagnosis (MR/MI) Workgroup has conducted regular meetings since September 2002 to address the needs of persons who require services and supports to address co-occurring mental retardation and mental illness (MR/MI). Its members represent the interests of consumers, families, advocates, the five Northern Virginia CSB, private residential providers, vocational day placement providers, community behavioral consultants, NVTC, NVMHI, and George Mason University. MR/MI Work Group (MR/MIWG) members represent both mental retardation and mental health service delivery systems.

While some individuals with MR/MI issues are served well, there is a general agreement and understanding that individuals with MR/MI are often underserved. Relatively few individuals with dual diagnosis need institutional care; but when it is needed, it should be easily obtained with the minimum of bureaucracy. The greatest need is for community-based mental health services that provide in-home supports, partial hospitalization and crisis stabilization. Interdisciplinary assessment and training is needed for staff of mental retardation and mental health agencies. MR/MIWG advocates basing services on individual consumer needs and supports rather than disabilities. A series of recommendations in the MR/MI Report, included as Appendix J, address system issues, treatment, education and training, and funding. The Steering Committee accepted the report and will explore these recommendations.

REGIONAL RECOMMENDATIONS FOR STATE-LEVEL ACTIONS

The participants in the planning process identified three issues that it wishes to recommend for state-level actions. These include:

- 1. Address several forensics/NGRI issues, including:
 - Advocating that SSDI be available again to forensic patients in facilities
 - Increasing the funding for follow along services that facilitate community integration and transition
 - Supporting expedited community integration
 - Studying the reasons for differential rates of adjudication, lengths of stay, and progress through the privileging system.
 - Initiating policy/Code changes that would allow people on NGRI status to be housed in a step-down program in the community prior to conditional release.
- 2. Support on-going consumer empowerment training, similar to the Consumer Education and Leadership Training (CELT) offered by the Mental Health Association of Virginia and the Wellness training. Encourage this training to be offered in Northern Virginia.
- 3. Implement a consumer and family affairs service.

REGIONAL PARTNERSHIP REINVESTMENT

Background

- At the request of the Commissioner of DMHMRSAS and with the active support of the Governor, each Region of the Commonwealth is developing a Regional Partnership Plan that will identify the steps necessary to decrease reliance on facility based services and improve our community-based system of care. The process involves stakeholders from throughout Northern Virginia who have been organized into a variety of work groups. Because of the size and complexity of the issues, the Steering Committee for the Northern Virginia Regional Partnership Planning Project decided to focus on the MH service delivery system for adults. An initial report is due in August of this year and a second report is due in August 2004. The full record of the proceedings, reference material and the membership of the various work groups can be found at http://www.fairfaxcounty.gov/service/csb/region/partnershipmain.htm
- Each Region has also been asked to develop a Reinvestment Initiative that would transfer funds from State mental health facilities to more community-based service approaches. Three regions had an initiative approved for FY 2004. Northern Virginia was scheduled to have a proposal for implementation in FY 2005. While the stakeholders continue to explore all options, in light of the growing demand and the uncertainty regarding the future capacity and location of private sector psychiatric beds, it is unlikely that beds can be closed at NVMHI and corresponding funds moved to the community.
- In 1992, the regional WINTEX project was established to reduce reliance on State mental health facilities. In 1998, WINTEX funds were incorporated into a more comprehensive project called Discharge Assistance and Diversion (DAD). The funds for this project are managed by NVMHI but controlled by a regional

Coordinating Committee and a regional Steering Committee. It has been quite successful in reducing the per capita utilization of State mental health facilities. This project has been responsible for purchasing beds from private psychiatric hospitals and for funding a variety of discharge assistance and diversion services.

■ In FY 2003, DMHMRSAS added about \$900,000 to the existing bed purchase budget of about \$800,000. An additional \$100,000 has been added for FY 2004. Thus, there is now approximately \$1.8 million available for the purchase of private psychiatric beds.

New Developments

- DMHMRSAS has asked the DAD Steering Committee to transfer the fiscal agent function from NVMHI to a CSB. Such a transfer can serve as a regional Reinvestment Initiative since the funds will be moved out of the NVMHI budget to a CSB. Furthermore, this will provide additional flexibility to the region in how the funds can be used. All other aspects of the project will remain unchanged.
- DMHMRSAS recently transferred \$550,000 in FY 2003 unencumbered funds in the DAD project to the Fairfax-Falls Church CSB to hold in escrow until the most appropriate regional entity can be identified. The other CSBs have asked Fairfax-Falls Church CSB to temporarily serve as the fiscal agent.
- The total funding for this Regional Reinvestment Initiative in FY 2004 will be about \$2.5 million. (\$1,800,000 for private sector bed purchase, \$550,000 to enhance diversion and discharge projects, \$50,000 for the discharge assistance fund and \$100,000 for administrative services.)
- DMHMRSAS has offered to continue the current contractual arrangement until November 1, 2003 while the details of this new arrangement are negotiated.
- Project funds can be used to cover administrative services. Included in the \$2.5 million total for the Reinvestment Initiative is \$60,000 in State funds available to assist with the Regional Partnership Planning Project.

Next Steps

- All CSBs and NVMHI will sign the interim agreement for the period July 1, 2003 through October 31, 2003.
- The DAD Steering and Coordinating Committees will develop proposals for the use of any unencumbered funds for FY 2004.
- Funding for the existing DAD Aftercare projects will be transferred to individual CSBs as soon as feasible.
- The Steering Committee of the Northern Virginia Regional Partnership Planning Project and the CSBs will be asked to endorse the concept.

- Fairfax-Falls Church CSB will develop the necessary administrative procedures so it can temporarily serve as the fiscal agent.
- Planning will begin immediately on developing a revised DAD agreement effective November 1, 2003 to transfer the fiscal agent responsibilities to a CSB.

Summary

This transfer of funds and the fiscal agent responsibilities to a CSB is consistent with the Governor's Reinvestment Initiative. The transfer will maintain the current collaborative structure of the DAD project, which includes all of the CSBs, NVMHI and DMHMRSAS. It will provide even greater flexibility in how the funds can be used without shifting any additional responsibility for providing inpatient services to CSBs. Project funds will also be used to cover related administrative services.

Reinvestment Project Manager Funds

Northern Virginia is proposing to use the \$60,000 for managing a reinvestment project in the following manner:

- Purchase technical assistance to complete the next phase of the Regional Report
- Assist consumers and family members to participate in the planning process by providing transportation, day care and other services
- Purchase technical assistance to facilitate the implementation of the Regional Reinvestment Project that involves the transfer of fiscal agent and other management activities related to the Discharge Assistance and Diversion program from the NVMHI to a regional entity.

Regional Partnership Planning Grants

The \$10,000 Regional Partnership Planning Grant was utilized to hire a consultant to support the activities of the MHWG and to assist in writing this report. CSBs and NVMHI provided assistance as needed to ensure that consumers and families could participate in the process. CSBs covered the expenses of conducting numerous meetings, forums and focus groups.

RESTRUCTURING OF STATE FACILITY AND COMMUNITY SERVICES WITHIN THE REGION

Significant restructuring is not recommended at this time. However, the reinvestment initiative requires the establishment of an entity to act as the fiscal agent. In order to achieve this, the structure of the NVACSB as well as the DAD Steering Committee will be reviewed.

PLAN FOR PHASE II FOR MH WORK GROUP

The MHWG has identified several issues that should be considered during the next planning phase. These issues include:

- A. Service Issues
 - 1. Recovery Model
 - 2. Move patients from institutions to community re: Olmstead
 - 3. Greater emphasis on employment services
 - 4. Services appropriate to settings, e.g., nursing home, jails, shelters
 - 5. PACT teams
 - 6. Availability of medications across the region
 - 7. Pharmacies
 - 8. Psychiatrists and nurses for medication clinics
 - 9. Resource gaps, especially residential, day programming and possibly in-home services
- B. Service Populations
 - 1. Youth and Families
 - 2. Persons with co-occurring mental illness and substance abuse
 - 3. Persons with co-occurring mental retardation and mental illness
- C. Forensics
 - 1. Use of earmarked funds for NGRI
 - 2. Community education re: use of Western State Hospital Forensics Unit
 - 3. Forensics population data
- D. Hospital Issues
 - 1. Use of private psychiatric hospital beds
 - 2. Differential utilization of Private Bed Purchase (PBP) by CSBs
 - 3. Random nature of monthly demand for PBP
- E. Funding Issues
 - 1. Reinvestment funds
 - a. Diversion strategies and services
 - b. Discharge strategies and services
 - 2. Incentives and disincentives
 - 3. Per capita expenditures
 - 4. WorkFORCE Action Grant Initiative
- F. Consumer Issues
 - Consumer Empowerment and Leadership Training (Mental Health Association of Virginia)
 - 2. Family education
 - 3. Consumer-directed services

APPENDIX A. VISION AND GUIDING PRINCIPLES

<u>Vision</u>

Development of a cost-effective, comprehensive, culturally competent array of recovery-oriented, consumer choice driven integrated services that are flexible and accessible to consumers and oriented toward proactive care, maintaining stability, and maximizing independence and community integration. Education must be intensified to combat and overcome discrimination historically associated with mental illness.

Guiding Principles and Objectives

1. Ensure Quality Services

- Education should be available on how to access services.
- Consumers and caregivers should be educated about how to get the most benefit from the services they receive.
- Sufficient capacity should exist throughout the system.
- Treatment and services should be available for Northern Virginians within the region.
- Outcomes should focus on recovery, quality of life, sufficiency and well being.
- A proactive model that avoids crises, both for individuals and the providers, should be achieved.
- Services should be based on best practice models and evidence-based research.
- Services should be culturally competent.
- Services should address the co-occurrence of behavioral and medical problems.
- Services should be guided by the principles of the Recovery Model, and education should be provided for self-management, self-advocacy and achieving wellness.

2. Ensure Consumer and Family Protections are in Place

- Fully educate consumers regarding their rights, assure compliance with human rights regulations and protect consumers against discrimination.
- Fully involve consumers, family members and caregivers in system-wide planning activities and program evaluations and provide them with adequate support when needed.
- Provide support appropriate to those exercising their rights under the Human Rights Regulations or other disability protections.
- Consumers and their families or guardians should be encouraged to communicate their concerns and interests to caregivers in order to fully participate in planning the system of services.
- Consumers, families and caregivers should fully participate in developing treatment plans. They should be able to exercise preference and choice in treatment services.

APPENDIX A

- Services at all points in the continuum will support self-management and minimize coercive measures; safety of clients and staff is paramount.
- Encourage consumers, families and caregivers to seek out educational resources.

3. Broaden Community Service Options

- Service options for persons with co-occurring mental illness and substance use disorder and for co-occurring mental retardation and mental illness disorder should be provided through an integrated system.
- Continuum of services should include full range of needed services, including acute hospital care and other medical services.
- Service options should emphasize community integration, utilize natural support systems, be easily accessible and include an array of employment and housing options.
- Service options should also include age appropriate services for youth transitioning to adult services and for older adults.
- Service options should include peer support and consumer-operated services.

4. Address Work Force Issues

- Strengthen recruitment and retention activities across the entire system including state facilities, CSBs and private providers.
- Develop mechanisms that facilitate the ability of staff to transfer to different employers within the system.
- Encourage training and employment of consumers as providers.

5. Maximize Revenue, Minimize Cost

- Fully utilize private and non-profit service providers to expand capacity and increase choices.
- Use cost benefit analysis whenever appropriate in planning system change.
- Balance accessibility and cost in Regional Program Planning.
- Pursue simplification of funding streams and elimination of unnecessary barriers to eligibility.
- Maximize Medicaid funding by enrolling consumers in Medicaid, encouraging providers to become Medicaid vendors and matching consumers to providers of Medicaid services.

APPENDIX B

APPENDIX B. COMMUNITY FORUMS AND CONSUMER FOCUS GROUPS

From mid-March through early April, there were fourteen separate community forums and consumer focus groups held across the Northern Virginia region to solicit input on the facility and community-based mental health service system. Below is a summary of the issues that were raised, often across several forums and focus groups. This input will be used in the ongoing planning process and incorporated into the interim report to DMHMRSAS by the Regional Partnership Steering Committee.

Summary of Issues from Community Forums

- Need to focus on regional solutions and need for regional collaboration of services, especially crisis care facilities, detoxification, psychiatric hospital beds
- Accessibility to psychiatric hospital beds in community when needed
- Need for more services to provide diversion from psychiatric hospitals and to facilitate discharge back to the community when ready
- Service needs of the homeless, especially those with mental illness and substance abuse
- Importance of support for families and care givers, as well as the need to help consumers build a social network in the community
- Need for more culturally competent services for those who need them
- Increasing problem of individuals without insurance not being able to access services
- Access to medications which are effective but very expensive
- Need for more consumer-run programs, especially drop in for evenings and weekends
- Lack of geographically accessible hospitalization and community residential and support services for geriatric population and need for support and education of family caregivers
- Importance of vocational programming, including job placement and job support, and need to expand these services
- Need for additional PACT programs across the region
- Lack of or inadequate public transportation which affects access to services
- Advocacy for sufficient funds for services
- Lack of services to inmates in local jails; need for more training for police, the judicial system and Fire & Rescue regarding how to relate to individuals with mental illness in community
- Need for waiver for adults with serious mental illness.

APPENDIX B

Summary of Issues from Consumer Focus Groups

- Importance of consumer and family input into program planning and development, and service delivery
- Need to incorporate Recovery Model into all aspects of service system
- Importance of having jobs, affordable housing with appropriate supports, and transportation
- Need for assistance with pursuing educational goals
- Importance of medications which can make significant difference in consumers' lives but which may not be affordable; newer medications not on State pharmacy list
- Need for staff who provide specialized (e.g. grief, anger management, etc.) services who can rotate around various regional sites to be more accessible
- Staff, especially psychiatrists, often do not have enough time to listen; consumers want more two way communication
- Consumers may not always feel like they are treated in a respectful and sensitive way by staff; they believe staff may not understand what it is like to be a consumer living on a limited income
- Appreciation of several staff mentioned who were helpful and dedicated in their work
- Many positive and helpful services were recognized but it was stated that there is often a waiting list
- Ongoing need for consumers in accessing benefits, including education about what
 is available and help in completing forms and navigating the application process;
 often problems and confusion around SSI and Medicaid, and answers to questions
 are not available
- Need for improved tracking of medical issues and access to appropriate medical specialists and modern medical technology and medications when needed
- More attention given to appropriate services for grief issues that individuals may have both in the psychiatric hospital and the community
- Need for better continuity of care between the jail and the community
- Need for more varied programming in clubhouses and group homes
- Recommendation that consumers have access to the internet in the hospital and the community to allow use of support groups, chat rooms, and access to literature

APPENDIX C. MEMBERSHIP

Regional Planning Steering Committee

Co-Chairs

Lynn DeLacy Northern Virginia Mental Health Institute

James A. Thur Fairfax-Falls Church Community Services Board

Members

Jane Anthony Parents and Associates of the Institutionalized Retarded

George Barker Health Systems Agency of Northern Virginia
Joanne Barnes Arlington Community Services Board

Mary Ann Beall Mental Health Consumers Association

John Beghtol Western State Hospital

Caitlin Binning National Alliance for the Mentally III-Virginia

Roger Birabin

Dean Bonney

John Boyd

Phill Bradbury

Ray Bridge

Joe Bullock

Loudoun Community Services Board

Arlington Community Services Board

Alexandria Community Services Board

Laurie Mitchell Employment Center

Arlington Community Services Board

Jessica Burmester Fairfax-Falls Church Community Services Board Roy Coffey Prince William Community Services Board

Mark Diorio
Stephanie Foran
Tom Geib
Mike Gilmore
Amanda Goza
Wendy Gradison
Betsy Greer
Northern Virginia Training Center
Loudoun Community Services Board
Prince William Community Services Board
Alexandria Community Services Board
Northern Virginia Mental Health Institute
Psychiatric Rehabilitation Services, Inc.
Arlington Alliance for the Mentally III

Waja Grimm
Parents and Associates of the Institutionalized Retarded
Joe Hinshaw
Northern Virginia Mental Health Institute Advisory Board
Randy Ihara
Substance Abuse and Addiction Recovery Alliance
Sharon Jones
Fairfax-Falls Church Community Services Board

Leslie Katz
Henriette Kellum
Cindy Kemp
Bob Lassiter
Jim Merrill
John Morrow
Shireda Prince
Northern Virginia Training Center
Arlington Community Services Board
Loudoun Community Services Board
Loudoun County Alliance for the Mentally III
Fairfax-Falls Church Community Services Board
Substance Abuse and Addiction Recovery Alliance

Lou Rosato Northern Virginia Mental Health Institute

Anne Sale Parents and Associates of the Institutionalized Retarded Ed Senft Parents and Associates of the Institutionalized Retarded Carol Urlich National Alliance for the Mentally III-Northern Virginia

Leslie Weisman Arlington Community Services Board Joanna Wise-Barnes Arlington Community Services Board

Alan Wooten Fairfax-Falls Church Community Services Board
L. William Yolton National Alliance for the Mentally III-Northern Virginia

Mental Health Work Group

Chair

Leslie Weisman Arlington Community Services Board

Members

George Barker Health Systems Agency of Northern Virginia

Loudoun Community Services Board Roger Biraben Arlington Community Services Board Joe Bullock Northern Virginia Mental Health Institute Caroline Csongos Lynn DeLacy Northern Virginia Mental Health Institute Kay Dicharry Loudoun Community Services Board Mark Diorio Northern Virginia Training Center Rosanne Faust Fellowship Health Resources, Inc. Sally Garrett Northern Virginia Mental Health Institute Amanda Goza Northern Virginia Mental Health Institute Psychiatric Rehabilitation Services. Inc. Wendy Gradison Alfred L. Head Northern Virginia Mental Health Institute Sharon W. Hoover Prince William Community Services Board Fairfax-Falls Church Community Services Board Sharon Jones

Jennifer Kane Northern Virginia Mental Health Institute
Leslie Katz Northern Virginia Training Institute

Jim Kelly Fairfax-Falls Church Community Services Board

Henriette Kellum
Cindy Kemp
Arlington Community Services Board
Arlington Community Services Board
Arlington Community Services Board
Northern Virginia Mental Health Institute
Alexandria Community Services Board
Northern Virginia Mental Health Institute
Northern Virginia Mental Health Institute
Walt Mahoney
Arlington Community Services Board

Joel McNair Pathway Homes, Inc.

John Morrow Fairfax-Falls Church Community Services Board

Marilyn Pasley Arlington Community Services Board

Russell Payne Virginia Department of Mental Health, Mental Retardation and Substance

Abuse Services

Rita Romano Prince William Community Services Board Lou Rosato Northern Virginia Mental Health Institute Kerrie Shrewsbury Northern Virginia Mental Health Institute

James Thur Fairfax-Falls Church Community Services Board
Carol Ulrich National Alliance for the Mentally III-Northern Virginia
Rev. L. William Yolton National Alliance for the Mentally III-Northern Virginia

Structural Work Group

Chair

Bob Lassiter Loudoun Community Services Board

Members

Phill Bradbury

Alexandria Community Services Board

Mike Gilmore

Dean Bonney

Arlington Community Services Board

Arlington Community Services Board

Arlington Community Services Board

Jessica Burmester Fairfax-Falls Church Community Services Board Fairfax-Falls Church Community Services Board

Stephanie Foran
Roy Coffey
Prince William Community Services Board

Older Adults with Mental Illness and Persons with Dementia Work Group

Chair

Henriette Kellum Arlington County Community Services Board

Members

Kathy Fowler Loudoun Community Services Board
Evelyn Hatfield Prince William Community Services Board
Richard Spector Fairfax-Falls Church Community Services Board

Rhonda Williams City of Alexandria

<u>Individuals with Co-Occurring Mental Retardation/Mental Illness Work Group</u>

Chair

Mark S. Diorio Northern Virginia Training Center

Members

Jane Anthony Parents and Associates of the Institutionalized Retarded

Jessica Burmester Fairfax-Falls Church Community Services Board

Lynn DeLacy Northern Virginia Mental Health Institute
Kathleen Egelund Alexandria Community Services Board
Alan El-Tagi Applied Behavioral Concepts, Inc
Roseanne Faust Fellowship Health Resources

Fred Firestone Loudoun Community Services Board Steve Garcia Loudoun Community Services Board

Russell Garth Parent

Susan Greene Community Systems, Inc.

Sharon Hoover Prince William Community Services Board

Leslie Katz

Cynthia Kemp

Jennifer F. Kurtz

Northern Virginia Training Center

Arlington Community Services Board

Arlington Community Services Board

Nancy Mercer The Arc of Northern Virginia

Brian Miller Prince William County Community Services Board

Johannes Rojahn George Mason University

Lou Rosato Northern Virginia Mental Health Institute

Jelena Saillard Community Residences, Inc

Mary Towle Department of Mental Health, Mental Retardation and Substance Abuse

Services

Christopher Tull Fairfax-Falls Church Community Services Board
Jackie Turner Prince William Community Services Board

Pat Vinson Job Discovery, Inc.

Joanna Wise-Barnes Arlington Community Services Board

Alan Wooten Fairfax-Falls Church Community Services Board

Private Psychiatric Hospitals Work Group

Co-Chairs

Lynn DeLacy Northern Virginia Mental Health Institute

James A. Thur Fairfax-Falls Church Community Services Board

Members

Wendy Atkinson Potomac Hospital

George Barker Health Systems Agency of Northern Virginia
Mary Ann Beall Mental Health Consumers Association
Roger Biraben Loudoun Community Services Board

Sandy Burns Potomac Hospital
Mary Butz Inova Health System
David Carlini Prince William Hospital
Colleen Cohen Inova Health System

Lynn DeLacy Northern Virginia Mental Health Institute Robespierre Maximillian Northern Virginia Mental Health Institute

Del Rio, MD

Mark Diorio Northern Virginia Training Center

Carol Gavin BMU, Loudoun Hospital

Tom Geib Prince William Community Services Board Mike Gilmore Alexandria Community Services Board

Kitty Harold Virginia Hospital Center Rodney N. Huebbers Loudoun Healthcare, Inc.

Cindy Kemp Arlington Community Services Board Bob Lassiter Loudoun Community Services Board

Jim Martinez Virginia Department of Mental Health, Mental Retardation and Substance

Abuse Services

Patricia J. Mook BMU, Loudoun Hospital

John Morrow Fairfax-Falls Church Community Services Board

L. Jean Reynolds Dominion Hospital/Northern Virginia Community Hospital

Jim Scott Inova Health System

James Thur Fairfax-Falls Church Community Services Board

H. Patrick Walters Inova Health System

APPENDIX D. STATISTICS

Population - 2000 and 2010

	2000	2010	% Change
Virginia (U.S. Census, Series A)	6,997,000	7,622,500	8.94%
Northern Virginia (Council of Governments)	1,814,997	2,183,100	20.28%

Source: US Census, Series A; COG

	2000	2010	% Change
Virginia (Virginia. Employment commission)	6,992,045	7,737,597	10.66%
Northern Virginia (Virginia Employment Commission)	1,752,101	1,992,403	13.72%

Source: Virginia Employment Commission

- Using COG projections, Northern Virginia will grow more than twice as fast as the rest of the state:
 - Virginia = 8.9% percent change in population
 - Northern Virginia = 20.3%
- Even if the more conservative projection estimates of the Virginia Employment Commission are used, Northern Virginia will still grow at a faster rate than the rest of Virginia.
 - Virginia = 10.7% percent change in population
 - Northern Virginia = 13.7%

Western State Hospital

	FY 2001	FY 2002	FY 2003
Admissions	118	156	118
Average Daily	45	45	49
Census			
Bed Days			
Adult Psychiatric	8,742	6,142	7,982
Forensic	5,186	8,021	8,389
Geriatric	2,186	875	502
TOTAL	16,114	15,038	16,873

Source: Western State Hospital

APPENDIX D

- Admissions to WSH from Northern Virginia were lower in FY 2003 than the previous year.
 - They were the same as in FY2001.
- Both Adult Psychiatric and Forensic bed days usage was higher in FY 2003 than the previous year.
- Bed days for Geriatrics, on the other hand, continue to fall.

Public Sector Adult Non-Forensic Bed Days/100,000 for FY 2003

	Bed Days (through 4-15-03)	Bed Days (estimated through 6-30-03)	Bed Days/100,000 (based on 2003 population estimates)
NVMHI	25,372	32,044	
Western State	6520	8235	
Central State	519	656	
Eastern State	475	600	-
SWVMHI	108	108	
CAT	3	3	
Total	32,997	41,671	2,165

Source: PRAIS

Note: Population Estimate for 2003 = 1,925,428 (COG)

	Bed Days (through 4-15-03)	Bed Days (estimated through 6-30-03)	Bed Days/100,000 (based on 2000 Census Data)
HPR I	36,596	46,217	4,533
HPR II	32,997	41,671	2,296
HPR III	62,131	78,463	6,000
HPR IV	29,515	37,274	3,059
HPR V	65,515	82,739	4,817
Total	226,754	286,364	

Source: PRAIS and Department of Health Statistics.

Note: Population estimates are based on 2000 Census Data; estimates for 2003 are available only for HPR II.

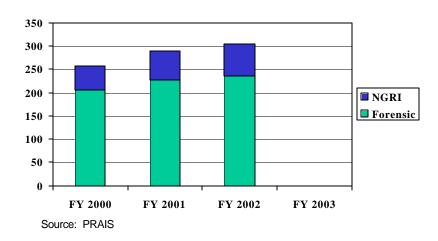
 Northern Virginia continues to have the lowest bed days usage per 100,000 of all the HPRs in the State

Forensic/NGRI at NVMHI:

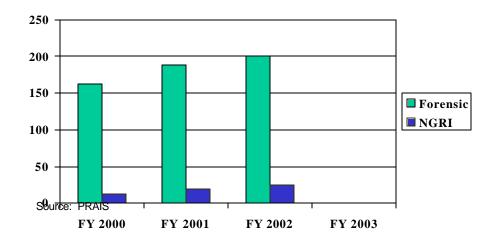
		FY 2003
NGRI		32
Forensic		1
	Total	33

Source: PRAIS; FY 2003 DAD Report

Forensic and NGRI Hospitalized Patients for Northern Virginia CSBs

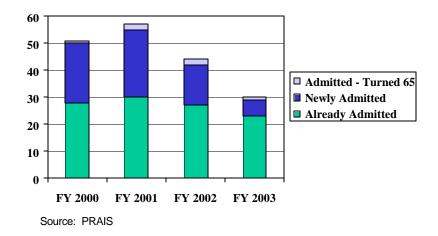


Forensic and NGRI New Admissions for Northern Virginia CSBs

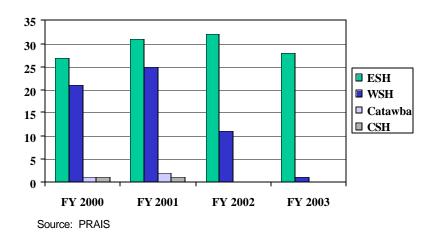


Geriatric Patients

Geriatric Hospitalized Patients for Northern Virginia CSBs

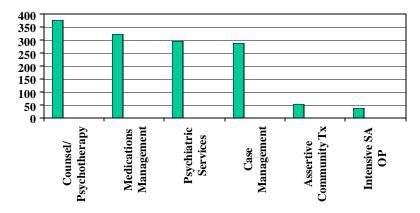


Geriatric Patients for Northern Virginia CSBs, by Facility



Unmet Services Needs

Northern Virginia CSBs' Wait List for Outpatient/Case Management Services



Source: Regional Submission to DMHMRSAS Comprehensive Plan 2004-2010

APPENDIX E. NVMHI LEVELS OF INPATIENT TREATMENT

The following four models of psychiatric inpatient care are intended to describe various levels of services required by people receiving inpatient psychiatric services. These four models are organized along the dimensions of acuity and complexity of mental health concerns of treatment recipients.

Acuity is a measure of immediate clinical status. High acuity may be characterized by current suicidal preoccupation; physically aggressive outbursts; serious verbal threats; high level of verbal and/or physical agitation; presence of disordered thinking; impairment in judgment; and/or confusion. Patients with high acuity may have an increased need for psychiatric monitoring, medical monitoring, and assistance with self-care, and may be less likely to actively participate in treatment.

Complexity is a measure of symptoms and experiences of individuals receiving psychiatric services, which can be more persistent over time. High complexity may be characterized by a history suggesting high suicide risk; danger to others; symptoms that significantly interfere with daily life, including self-care; substance abuse; medical complications; instability or absence of social support; instability of work history; residential instability; difficulty engaging in treatment; medication non-adherence; limited knowledge of illness; and limited or no family involvement.

- "Patient Profiles" describe symptoms and experiences often encountered at each level of care.
- "Interventions" illustrate typical services required by service recipients at the various levels.
- "Expected Outcomes" describe treatment goals commonly identified at each level of service.

LEVEL I: Acute Stabilization (Admissions)				
Patient Profile	Interventions	Expected Outcomes		
High Acuity Low Complexity Presentation may include: Substance-induced symptomatology Situational crises (adjustment disorder) Situational difficulties resulting from Axis II symptomatology Not taking prescribed medication or in need of medication adjustment (with history of good response to medication)	Acute Stabilization requires a multidisciplinary treatment model and a higher staff to patient ratio than intermediate care or rehabilitation services. Interventions are focused around resolution of psychiatric crisis and rapid return to the community. Although they will vary depending upon the individual and the nature of the presenting problem, interventions typically involve: Increased level of observation Highly structured treatment milieu Risk assessment Frequent, ongoing clinical assessment Patient and family education and involvement Cultural/interpretive services Acute crisis counseling Detoxification management Medication stabilization Medication education Potential need for physical interventions to manage self-injurious or aggressive behaviors Medical management, including potential for emergency medication Immediate, aggressive discharge planning	 Short length of stay (2-5 days) Rapid stabilization of symptoms Resolution of risk/safety issues Effective continuity of care plan Linkages with substance abuse services Timely communication and appointments with community providers 		

LEVEL II: Intensive Care (Admissions)

Patient Profile

High Complexity
High Acuity

Presentation may include:

- Unsafe behaviors requiring intervention
- Lack of willingness or ability to participate in treatment

<u>Interventions</u>

Intensive Care necessitates an interdisciplinary treatment model to fully address complexity of presenting problems, and interventions require a higher staff to patient ratio than intermediate care or rehabilitation services. Interventions are focused around resolution of more long-term, persistent or recurrent psychiatric difficulties and return to the community with the expectation of improved community tenure. Treatment may be characterized by:

- Possible increased level of observation
- Structured treatment milieu
- On-going risk assessment
- Frequent, ongoing clinical assessment
- Legal authorization of treatment
- Flexible assessment and treatment approaches
- Highly individualized services
- Modalities which encourage motivation and engagement in treatment
- Patient and family education and involvement
- Cultural/interpretive services
- Group and individual treatment modalities
- Behavioral assessment and intervention services
- Primary care services to address medical co-morbidity
- Stabilization & on-going management of medical issues
- Medication education
- Medication management
- Potential need for physical intervention
- Potential need for emergency medication
- Individualized, creative, and flexible discharge planning
- Supported transition to community services

Expected Outcomes

- Length of stay 30 days or less
- Stabilization of symptoms
- Resolution of risk issues
- Effective continuity of care plan
- Highly individualized discharge plan, including co-morbidity issues addressed
- Linkages with community substance abuse services
- Linkages with Primary Care service in community
- Timely communication/ appointments with community providers
- Beginning readiness to explore relapse prevention and recovery

LEVEL III: Intermediate Care

Patient Profile

High Complexity Variable Acuity

Presentation may include:

- Residential instability
- Sustained imminence of risk to self or others
- Problematic behaviors with complex etiologies
- Inconsistent selfmanagement of symptoms or need for changes in relapse prevention plan

Interventions

An interdisciplinary treatment model is required to address complexity found at this level of care. Staffing levels that are lower than acute or intensive care levels of care, but which have flexibility to address variable acuity, are required for this level of care. Treatment is focused on resolution of identified barriers to recovery and identification of placement and services supportive of a successful transition to, and tenure in, the community. Interventions may include:

- Variable levels of observation
- Structured treatment milieu
- On-going risk assessment
- Possible legal authorization of treatment
- Modalities which encourage motivation and engagement in treatment
- Patient and family involvement and education
- Cultural and interpretive services
- Psychosocial Rehabilitation programming
- Vocational Rehabilitation services
- Skill building
- Behavioral assessment and intervention services
- Substance abuse programming, services, and referrals
- Forensic services
- Co-morbidity/ Primary care services
- Complex medication management
- Potential need for physical intervention
- Potential for emergency medication
- Extensive residential planning
- Creative discharge planning, including consideration of step down or wrap around services
- Supported transition to community services

Expected Outcomes

- Length of stay greater than 30 days
- Stabilization of symptoms to support recovery and relapse prevention
- Attainment of functional skills required for goal achievement and recovery
- Progression through NGRI privileging process
- Linkages with outpatient substance abuse and primary care services
- Successful transition to community-based living situation

LEVEL IV: Rehabilitation Services			
Patient Profile	<u>Interventions</u>	Expected Outcomes	
High Complexity Low Acuity Presentation may include: • Medical complications • Lack of confidence in ability to recover • Lack of clarity around recovery goals	A multidisciplinary treatment model with a lower staff to patient ratio and more independent involvement in treatment and recovery is characteristic of this level of care. Focus of treatment is on solidification of adaptive skills, independent management of chronic symptomatology, and development of community supports and a network of services to support enduring success following discharge. Interventions at this level of care typically include: Motivational/engagement modalities Recovery model Patient and family education and involvement Cultural/Interpretive services Psychosocial Rehabilitation programming Vocational rehabilitation services Transportation skill building/services Forensic services Substance abuse programming/referrals Emphasis on independent medication management (vs. medication education) Medical illness management/primary care services Discharge planning Extensive residential planning Community reintegration Supportive transition services	 Length of stay greater than 30 days Maintenance of symptoms at baseline Acquisition of adaptive skills and improvements in adaptive functioning Identification and clarification of recovery goals Increased self confidence and hope Progression through NGRI privileging process Maintenance of medical/physical health Successful transition to residential placement 	

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APPENDIX F

APPENDIX F. RECOVERY MODEL

Recovery is often called a process, an outlook, a vision, a conceptual framework, a guiding principle. There is no single agreed upon definition of recovery and no single way to measure it. However, the main message is that hope and restoration of a meaningful life are possible, despite serious mental illness (Deegan, 1988, Anthony, 1993). Recovery is "...both a conceptual framework for understanding mental illness and a system of care to provide supports and opportunities for personal development. Recovery emphasizes that while individuals may not be able to have full control over their symptoms, they can have full control over their lives. Recovery asserts that persons with psychiatric disabilities can achieve not only affective stability and social rehabilitation, but transcend limits imposed by both mental illness and social barriers to achieve their highest goals and aspirations." (The Recovery Model, Contra Costa County, California).

Distinguishing Features of the Recovery Model

The following are the fundamental assertions of the Recovery Model of mental illness cited in the Contra Costa County Recovery Model concept paper cited above.

- a holistic view of mental illness that focuses on the person, not just the symptoms
- recovery is not a function of one's theory about the causes of mental illness
- recovery from severe psychiatric disabilities is achievable
- recovery can occur even though symptoms may reoccur
- individuals are responsible for the solution, not the problem
- recovery requires a well-organized support system
- consumer rights, advocacy, and social change
- applications and adaptations to issues of human diversity.

More information about recovery can be found at: http://www.mhrecovery.com

References:

Anthony, W. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990's. Psychosocial Rehabilitation Journal, 16(4), 11-24.

Deegan, P.E. (1988). Recovery: The lived experience of rehabilitation. Psychosocial Rehabilitation Journal, 11(4), 11-19.

Mahler, Tavano, Gerard, Baber (2001). The recovery model: A conceptual framework and implementation plan, Contra Costa County Mental Health Recovery Task Force, October 2001, 1-8.

APPENDIX G

APPENDIX G. LETTER TO COMMISSIONER REINHARD

Northern Virginia Regional Partnership Planning Project

c/o Fairfax-Falls Church Community Services Board 12011 Government Center Parkway, Suite 836, Fairfax, Virginia 22035-1105 (703) 324-7000

March 18, 2003

James Reinhard, M.D., Commissioner
Department of Mental Health, Mental Retardation
and Substance Abuse Services
P.O. Box 1797
Richmond, Virginia 23218-1797

Dear Commissioner Reinhard:

On behalf of the Steering Committee of the Northern Virginia Regional Partnership Planning Project, we wish to share several concerns as well as some preliminary observations about the demand for mental health services – especially inpatient services – in Northern Virginia.

As you are aware, our region is barely able to meet current needs despite having the lowest per capita rate of using State facilities. In addition, we have a growing population, reduced local funding for some CSBs, and the possibility that some private providers of inpatient psychiatric care may either relocate or reduce the number of adult inpatient beds operated in Northern Virginia. As a result, there is a serious concern that Northern Virginia may actually require additional publicly funded mental health services – including inpatient psychiatric care – over the coming years. Therefore, members of the Steering Committee want you to know that it does not seem feasible at this time to reduce the bed capacity at the Northern Virginia Mental Health Institute (NVMHI). However, our final report in August of 2003 will reflect the results of our efforts to identify other reinvestment opportunities. Until such time as we have completed our report and analyzed our bed purchase requirements for FY 2004 and FY 2005, we are requesting that you leave all existing bed purchase funds in the NVMHI budget.

In the meantime, we will work aggressively to explore all options to further improve the effectiveness and efficiency of our regional system of care. We also join with many other citizens throughout the Commonwealth in supporting the concept of developing a system of care that is truly community-based. We also wish to complement you on taking the initiative to establish a planning process that is truly inclusive and comprehensive.

establish a planning process that is truly inclusive and comprehensive.
Sincerely,
James A. Thur
Lynn DeLacy

APPENDIX H. STRUCTURAL WORK GROUP REPORT

	Issue	Discussion	Next Step
1.	Information Technology	There is unlikely to be significant collaborative potential across all Boards and facilities given the level of investment in different management information systems. However, it was noted that there might be a potential in the future for further collaboration among the three Boards (Alexandria, Arlington, and Fairfax-Falls Church) that use the Anasazi software application.	Meeting of representatives of the five CSBs and the two State facilities to review current practices, identify common areas of interest and possible areas of collaboration.
2.	Training	There could be significant benefit from a more regional approach to many areas of training including required training for new staff and annual recertification; clinical professional training; vendor training needs, training on specialized topics, e.g. the Recovery process. Benefits could include saving expenses by holding larger training events, improving attendance by conducting training events across the region and by establishing a website to list all regional training events.	Meeting of Training Coordinators from the five Boards and two Facilities
3.	Quality Assurance/ Quality Improvement	Each Board and Facility has staff that is attending to QA/QI activities. It is expected that there is significant similarity among the areas of focus for these staff, although the specific methods and approaches used probably are quite variable. Corporate compliance and risk management should also be included in any further analysis.	Meeting of QA/QI staff from the five Boards and two Facilities to review existing QA/QI activities and allow opportunities for sharing of useful procedures and consultation and problem solving around common dilemmas.
4.	Reimbursement Activities	Since reimbursement activities are so integrated with all other local service and administrative activities, it was not possible at this time to identify areas for regional integration or collaboration that would achieve any significant cost savings or improvement in revenue collection	None at this time

	Issue	Discussion	Next Step
5.	Centers of Excellence	A specific area for regional collaboration was identified in the potential use of skilled staff from NVMHI and others in the region to provide regional training and consultation on areas of expertise such as behavioral specialist consultations and training on managing aggressive behavior with non-coercive strategies. The specific example for regional collaboration involved the potential for NVMHI to provide training and consultation on managing aggressive behavior with non-coercive strategies.	Share the expertise from NVMHI and consider other possible components of a regional Center of Excellence focused on Mental Health topics. Identify other Centers of Excellence, e.g., Recovery Model, Dual Diagnosis, Geriatrics. Involvement of the private hospitals with psychiatric inpatient units will also be encouraged as a part of this initiative.
6.	Cultural Competence	It was agreed that provision of services that are sensitive to and directed to the particular cultural background of the consumer is an important issue for the entire Northern Virginia region. There may be opportunities for regional collaboration and the sharing of expertise, since many cultural groups and immigrant communities are more regional in nature. There may be a need to begin sharing specialized training staff involved in the provision of culturally competent services.	This issue will be included on the agenda of the meeting of the Training Coordinators of the five Boards and the two Facilities.
7.	Evidence-based Practices	With the continuing growth of evidence based practices that are being made available in all disability areas and the goal of providing the most efficient and effective services possible, it was agreed that there could be significant benefit from approaching the research of and implementation of evidence based practices on a regional level.	This issue will be included in the meeting of QA/QI staff from the five Boards and two Facilities. The Mental Health Directors of the five Boards will be asked to play a leadership role in implementing these practices.

	Issue	Discussion	Next Step
8.	Services for Deaf and Other Specialized Populations	It was agreed that this was an important aspect of service delivery for all providers and needed further study and review of existing resources and future needs.	Meeting of the Fairfax-Falls Church-based regional Coordinator of Deaf Services, Deaf Resources staff lead for Psychiatric Rehabilitation Services, Inc., and any other relevant providers to develop a current status report of services for these populations. There was agreement to convene at least annual regional meetings with these services as the focus.
9.	Prevention	Prevention Coordinators from throughout the region currently meet on a regular basis to review and monitor community needs as well as to share and coordinate prevention strategies.	The group will be encouraged to continue their regular meetings and to place a special emphasis on promoting the use of evidence based practices.
10.	Regional Approach to Grants	There was consensus that pursuit of available grants was an important adjunct to state and local funding for services across the region. However, because of the unpredictable nature of grant announcements and the often quick response deadline, as well as the close collaboration with local government, other local agencies, and local community groups that are often required to be demonstrated in the grant response; it was decided that there may be limited opportunity for regional collaboration in this area. However, there is an expectation that a high level of regional collaboration will continue when it is required by the nature of the grant.	None at this time.
11.	Collaboration with Various Community Organizations	Although it was agreed that there may be limited opportunities for regional collaboration with those community organizations that were active throughout the region, this is an area that is more likely to be effective on a local level because of the close local interaction and communication between the individual Boards and Facilities and the particular local group. It was noted that there might be additional opportunities for the two State facilities to be involved in these collaborative endeavors with the community.	None at this time

	Issue	Discussion	Next Step
12.	Emergency Response/ Management	This is an area in which multiple teams have had and continue to have active involvement both locally and across the region. During a declared disaster, DMHMRSAS will work with CSBs to ensure they can handle their local needs and/or request CSBs in non-effected areas to provide assistance, when possible, to other CSBs.	None at this time
		In Northern Virginia, each CSB coordinates their emergency preparedness planning with their respective local government(s). Local jurisdictions also plan and coordinate activities with the US Department of Homeland Security and the Metropolitan Counsel of Governments (COG). The first priority of the CSB is to respond to local consumer and community needs and to assist other localities if possible.	
		At the local level, during a disaster, responsibilities of CSBs include providing crisis counseling and emergency services to first responders, and to victims of disasters, as well as ensuring continuity of CSB residential and outpatient services for consumers already in the care of the CSB.	
13.	Maximization of Medicaid Revenue for the Region	There is a need to maximize use of Medicaid funded services for individuals who have Medicaid or who are Medicaid eligible. For example, persons who require mental health inpatient psychiatric services could be referred to a facility in which Medicaid can be used as a reimbursement resource. This would involve referral to a facility that can bill Medicaid at the point of assessment for need for psychiatric inpatient services. This may also involve possible transfer of Medicaid eligible patients from NVMHI to a facility that can bill Medicaid for services.	Issue to be added to the agenda of the Northern Virginia Regional Partnership Private Hospital Work Group.
14.	Coordination of Regional Mental Health Issues	The five CSBs and the State facilities have many common concerns that can sometimes be most effectively and efficiently addressed through a coordinated approach. The differing structures of each Board and the State facilities have sometimes made it difficult for the leaders of the MH systems to coordinate their activities.	Strengthen the current structure of the Regional MH Council by ensuring that each Board and State Facility is properly represented on an ongoing basis.

APPENDIX I. OLDER ADULTS WITH MENTAL ILLNESS AND PERSONS WITH DEMENTIA WHO HAVE PSYCHIATRIC SYMPTOMS

Introduction: "The Crisis"

The Older Adult population is expanding rapidly, and perhaps in anticipation of the increased costs of care this will bring, there has been a gradual process of "defining older persons out" of the existing mental health system of services. This has been done by creating different admission criteria to State Hospitals for persons with Dementia and those over age 65 than for non-dementia clients or younger clients, assuming that Nursing Homes can provide for acute psychiatric needs when Nursing Homes are not appropriately staffed and have greater restrictions on the use of restraining safety measures than do psychiatric hospitals, and by establishing Priority Population/SMI criteria that favor those under age 65. Additionally, outpatient programs such as psychosocial day and residential often do not consider the needs of older adults in their daily programming.

State Hospital policy on admissions for clients with Dementia:

In order for an adult with a diagnosis of Dementia to be hospitalized in the State mental health system, the request must go through the Receiving State facility (Eastern State Hospital or NVMHI for under age 65 clients). Without directly examining the client, Eastern State must concur that the "behavioral" problems are acute and will remit with inpatient care. The State Hospital, therefore, has the right to refuse hospitalization to adults with Dementia even if those clients meet legal commitment criteria.

Dementia clients can be denied a state hospital bed by the receiving facility even if a bed is available in the hospital. Without the designation of a bed, CSB staff cannot proceed to a commitment hearing, even if the client meets commitment criteria based upon the pre-commitment screening.

Issues:

Clients of any age who have a diagnosis of Dementia can be denied psychiatric treatment in a State Psychiatric Hospital even if their behavioral symptoms are identical to clients without a diagnosis of Dementia, and even if their behavioral symptoms are sufficient to meet commitment criteria.

In the current system, the denial of treatment of a Dementia client in a State Psychiatric Hospital is done on the basis of a written or verbal report, <u>not</u> upon a face-to-face assessment of the individual. In effect, the face-to-face assessments built in to the precommitment screening and the commitment hearing to <u>prove</u> the individual's least restrictive level of care is involuntary commitment can be over-ridden by someone in a State psychiatric Hospital reading or taking a verbal report.

State Hospital Availability:

Western State Hospital Geriatric Center has closed. Northern Virginia Clients who are 65 and over now are in the Eastern State catchment area. The Local State mental hospital, NVMHI does not admit clients 65 and over for any mental health reason.

Issues:

Clients over age 65 can generally be considered the frailest of mental health clients, yet anyone in this age group who requires state psychiatric hospitalization must travel even greater distances than previously and are denied local state hospitalization. Such clients also have the frailest of social supports. Friends and family of older adult clients may find traveling to Eastern State an insurmountable hardship compared to a local location. Persons providing social supports, therefore, are limited in their participation in treatment and discharge planning.

Nursing Homes as Alternative to Hospitalization

Older adults and Dementia clients with behavior problems are often referred for Nursing Home placement. Those clients who have a psychiatric diagnoses or exhibit behavioral symptoms indicative of a psychiatric diagnosis must pass a Level II pre-screening required by Medicaid before admission to a Nursing Home. The purpose of the Level II pre-screening is to ensure that older adults with mental health problems receive active psychiatric treatment, including inpatient hospitalization, before being accepted into a nursing home. Those clients with a Dementia diagnosis, regardless of whether or not they exhibit behavioral symptoms indicative of a psychiatric diagnosis, are exempted from the Level II pre-screening.

Issues:

Older adults who need supervised care may be denied nursing home placement because of mental health/behavioral problems, but may also be denied psychiatric treatment in a State Mental Hospital because of their age/diagnosis of Dementia. Where are such individuals to go?

If the older adult has a diagnosis of Dementia, he may be admitted to a nursing home even though he is in need of inpatient psychiatric treatment. He may, therefore, receive the supervision required but be denied the level of psychiatric treatment he needs.

Although psychiatrists may see clients in nursing homes, they cannot do so as intensively as on a psychiatric unit. Furthermore, the 24-hour support staff on a psychiatric unit are expert in the care and treatment of persons with psychiatric illness. One cannot expect to find such expertise in a nursing home, even among highly skilled staff. The expert monitoring and intervention on the psychiatric unit, therefore, cannot be performed in a nursing home.

Nursing homes have restrictions by regulation to use some interventions essential in the treatment of extremely behaviorally disordered clients. These include stringent regulations against the use of chemical or physical restraints that are permitted to be used in psychiatric hospitals; therefore, hospitals have the tools necessary to ensure the safety of clients and staff while waiting for other treatments to become effective, while nursing homes do not.

<u>Hospitalizing in Private Psychiatric Hospitals/Units – Another Double-bind</u>

Private psychiatric facilities may appear to be the solution to the above problems involving nursing homes and State Psychiatric Hospitals; however, private psychiatric hospitals, who depend upon third party payers for their survival, may deny admission of older adults or Dementia clients unless there is a guarantee that there is a place for them to go after discharge or after their insurance days expire.

Additionally, clients with severe Dementia lack the capacity to sign themselves in to a psychiatric hospital voluntarily, but, by law, a guardian cannot sign the client in to a psychiatric hospital (A guardian can sign a client in to a hospital for medical treatment, however). Involuntary commitment in a State Mental Hospital becomes the only alternative.

Issues:

The criteria for involuntary commitment are much more strict that the criteria for voluntary admission to a psychiatric hospital. If a Dementia client does not have the capacity to sign himself in for a voluntary hospitalization, voluntary hospitalization for psychiatric/behavioral problems is a treatment denied him. A non-demented client with the same psychiatric symptoms, however, will have access to voluntary hospitalization.

At best, the Dementia client will be made to endure longer periods of suffering than his non-demented counterpart, and will have fewer cognitive resources to cope with such suffering.

At worst, treatment may be denied to the Dementia client until his condition deteriorates to levels that would meet involuntary commitment criteria, levels that may also compromise his health, his safety, his life (and as discussed above, reaching commitment criteria is no guarantee that a State Mental Hospital will agree to treat the client).

Emergency Services through the CSB are tasked with pre-screening for detention/commitment. The usual procedure is to seek detention in a private psychiatric facility if the pre-commitment screening shows that commitment criteria are met. Under some circumstances, a non-demented client has the right to agree to voluntary psychiatric hospitalization and avoid commitment. A Dementia client who lacks capacity is denied this right.

Additionally, there is always the possibility that a client initially detained or committed to a private facility may eventually need to be transferred to a State facility. In such instances, the same impediments to psychiatric hospitalization in State Mental Hospitals exist that have been discussed above.

Clients experiencing severe Dementia who lack capacity are denied voluntary psychiatric hospitalization and are restricted from State hospitalization by regulations that do not apply to clients who do not experience dementia.

Maintaining Nursing Homes as a Resource

Nursing Homes, Assisted Living Facilities and Group Homes are, thus, often caring for clients whose behaviors render them inappropriate for such settings. Statistics show that nursing home populations have a high rate of psychiatric illness; therefore, their clients may be expected to need psychiatric hospitalization at rates higher than other populations. But, for the reasons discussed above, the nursing home population (mostly older adults and/or demented) have almost insurmountable restrictions on being hospitalized psychiatrically when the need arises.

Issues:

Nursing home facilities have become more and more reluctant to accept clients who have a psychiatric diagnosis, or who exhibit difficult behaviors. Nursing homes do not have the resources to care for such clients when their psychiatric conditions deteriorate, and nursing homes cannot rely on the Mental Health system to assist them when such clients require psychiatric hospitalization, including when such clients meet the criteria for involuntary commitment.

Priority Population/SMI criteria are not written with Older Adults in mind

The State mandates a priority for the treatment of the most psychiatrically ill client, but the criteria to include clients in priority categories favors those persons under age 65.

For example, the criteria for Priority Populations/SMI designation include ability to function well enough to maintain employment, but most older adults are not in the work force, as their age qualifies them for Social Security. The Priority Population criteria specifically exclude diagnoses of Dementia.

Issues:

The Priority Populations/SMI criteria are not written with the issues of the older adult in mind; therefore, fewer older adults qualify for this designation and fewer State dollars are available for services for this population. As has been described over and over in the above, however, older adults are one of the most vulnerable of populations and a population that currently has mental health resources denied them. At the same time, the population of older adults is the fastest growing of all age groups.

Conclusion:

These problems have been observed by professionals in the Older Adult Programs of Community Services Boards, and have been corroborated by Aging and Dementia Advocacy Groups, Emergency Mental Health Services, Health Organizations, Social Services Agencies and Adult Protective Services Agencies.

In summary, the Older Adult population is expanding rapidly, and perhaps in anticipation of the increased costs of care this will bring, there has been a gradual process of "defining older persons out" of the existing mental health system of services. This has been done by applying different and more stringent admission criteria at State Hospitals than are used for those under age 65, excluding Dementia as a valid diagnosis for admission even if the client meets all criteria for involuntary commitment, assuming that Nursing Homes can provide for acute psychiatric needs when Nursing Homes are neither appropriately staffed nor can use restraining safety measures used by hospitals, and by establishing Priority Population/SMI criteria that favor those under age 65.

If left unaddressed, the problems outlined in this paper will compound as the aging population increases in number.

Proposals:

The Northern Virginia Alliance for Geriatric Mental Health Care, which developed this document, is submitting the following three proposals for consideration by the State:

- 1. We request a study to be done by an independent group on the following four older adults with mental illness issues:
 - Psychiatric hospitalization, both public and private
 - Institutional placement, including nursing homes and assisted living facilities
 - Age appropriate availability of the full range of services offered by Community Mental Health Centers, including psychosocial day programming, housing, emergency services and outpatient treatment services,
 - And private community resources.

We would like the study to look at the cascading impact of the decisions that have been made to reduce the number of in-patient geriatric beds in the State system, we would like the study to look at the problems of hospitalizing geriatric clients who are in need of psychiatric hospitalization, including those with Dementia, we would like the study to look at the long-term care needs of older adults who are mentally ill and we would like the study to look at the availability and age-appropriateness of the full range of services in community mental health centers.

2. We recommend that the criteria for Priority Populations be re-written to be more inclusive of older adults, and adults who have behavioral and psychiatric symptoms related to Dementing illnesses.

3. We recommend that a pilot program be initiated to develop a coordinated approach for a continuum of care between the following groups: one or two nursing homes, one or two Assisted Living Facilities, a community mental health geriatric program, a community mental health emergency service, a local medical hospital psychiatric unit and a State geriatric psychiatric unit.

The goal of this program would be to demonstrate that with the assurance of placement between an in-patient psychiatric hospital and a nursing home and vice versa, clients who are now considered to be difficult to place can be maintained in the community or nursing home rather than require placement in a State Geriatric psychiatric facility. As long as the community, nursing homes and Assisted Living Facilities have the assurance that clients who become difficult for them to manage can be psychiatrically hospitalized for a stabilization period, and as long as hospitals have assurance from nursing homes and the community that there will be guaranteed placement after discharge, the flow of clients between facilities to maximize stable functioning will be eased. The end result will be a more stable client, a more willing nursing home, and a more willing hospital.

Costs:

- Community Mental Health Program 2.5 FTE's
 - o Case management
 - o Coordinate Program/maintain contacts
 - o Maintain data collection
 - o Training of Nursing Home/Assisted Living Facility staff
 - o Consultation/Liaison with various facilities/individuals involved
- Nursing Home additional aides: 3
 - o Serves 6 high maintenance clients
- Assisted Living Beds: 3

Nursing Home and Hospital Costs: Medicare/Medicaid/State dollars for clients who are uninsured. Most clients over age 65 have Medicare for Hospital

The Northern Virginia Aging Network (NVAN) has endorsed the issues outlined in this document.

APPENDIX J. INDIVIDUALS WITH CO-OCCURRING MENTAL RETARDATION AND MENTAL ILLNESS

Background

In July 2002, the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) convened a Statewide Dual Diagnosis Steering Committee to address the needs of the citizens of the Commonwealth of Virginia who require services and supports due to the co-occurrence of the conditions of mental retardation and mental illness (MR/MI). The DMHMRSAS Dual Diagnosis Steering Committee Vision Statement is:

The Virginia DMHMRSAS will engage in collaborative partnerships to develop state-of-the-art services and supports for individuals who require care and treatment related to the co-occurrence of the conditions of mental retardation and mental illness. The partnership will seek to (1) identify the prevalence of this dual diagnosis, (2) reduce barriers to treatment, (3) identify best practices models, and (4) train service providers, consumers and families.

The DMHMRSAS Dual Diagnosis Steering Committee goals and objectives are to:

- Determine the prevalence rate of dual diagnosis in Virginia.
- Study the demographics of current cases.
- Improve the accuracy of diagnoses for this population.
- Develop a vision statement that will foster a creative and cooperative service delivery system that values integration of services and stressing that this is a joint project for public and private service providers and specialized agencies (i.e., mental retardation, mental health and substance abuse services).
- Define or identify training needs, standardize training curriculum and requirements, develop a specific dynamic didactic training model.
- Determine the service delivery gaps that exist within the current care or service delivery configurations through a gap analysis.
- Determine incentives for service delivery.
- Identify a good practice model and a list of experts.
- Establish university contacts and liaisons.
- Establish conference planning.
- Identify and seek funding, grants and technical assistance.

The DMHMRSAS Steering Committee also requests that each State Health Planning Region (HPR) create a MR/MI Regional Workgroup to better address regional issues, differences in population and resource allocation. Every regional workgroup is expected to:

- Collaborate with and assure membership from all mental retardation and mental health stakeholders, including consumers, families, advocates, state facilities, community services boards (CSBs), schools, residential and vocational vendors, universities, private community hospitals, etc.
- Conduct service and treatment delivery gap analysis for each region.
- Analyze system capacity for service delivery, including emergency services, crisis prevention, and stabilization.
- Analyze regional strengths and weaknesses; prioritize areas for improvement.
- Define regional priorities.
- Identify regional experts.
- Review and update the regional MR/MI protocols; review other regional protocols for possible items to include in the regional protocol.
- Validate state-derived prevalence data and provide detailed regional data.
- Develop a regional consultation team (PACT team model) or other appropriate program alternatives or treatment options. This team would act as a consultation source for the region.
- Develop topics of regional interest for the upcoming state-sponsored Best Practices Conference.

Northern Virginia MR/MI Workgroup Process

This report represents the HPR II Workgroup's efforts to respond to the expectations for each regional workgroup and to address some of the broader issues identified in the DMHMRSAS Dual Diagnosis Steering Committee's goals and objectives. The MR/MI Workgroup has conducted regular meetings since September 2002. The Northern Virginia Workgroup members are derived from a large group of stakeholders chosen to best represent the interests of consumers, families, advocates, the five (5) Northern Virginia Community Services Boards (Alexandria, Arlington, Fairfax/Fall Church, Loudoun, and Prince William), private residential providers, vocational day placement providers, community behavioral consultants, Northern Virginia Training Center (NVTC), Northern Virginia Mental Health Institute (NVMHI), and George Mason University. Workgroup members are from both mental retardation and mental health service delivery systems.

The process of the Northern Virginia Regional MR/MI Workgroup (hereafter referred to as the MR/MI Workgroup) has been similar to other successful regional collaborations. Members have devoted considerable time and expertise to the Workgroup and significant progress has been made on a number of issues.

<u>Mission Statement – Work Group</u>

The mission of MR/MI Workgroup is to advance mental wellness for persons with mental retardation and other related conditions through the promotion of excellence in community-based mental health services and supports.

<u>Vision and Guiding Principles – Work Group</u>

The MR/MI Workgroup fully endorses the Vision and Guiding Principles set forth by the Northern Virginia Regional Partnership and the DMHMRSAS Dual Diagnosis Steering Committee.

<u>Definition of Dual Diagnosis</u>

The MR/MI Workgroup adopted from the National Association for the Dually Diagnosed (NADD) the broad definition of dual diagnosis as *the co-existence of the manifestations* of both mental retardation and mental illness." Additional detailed clarification on the meaning of dual diagnosis can be found in Attachment 1.

Northern Virginia Regional MR/MI Protocol

The members of the workgroup determined that there are no existing Northern Virginia regional MR/MI protocols for admission and discharge to review or update. The Northern Virginia CSBs, Northern Virginia Training Center (NVTC) and Northern Virginia Mental Health Institute (NVMHI) will use the current DMHMRSAS Admission and Discharge Protocols for Persons with Mental Retardation Served in State Mental Retardation Facilities, the Discharge Protocols for Community Services Boards and State Mental Health Facilities, and the Procedures for Continuity of Care Between CSBs and State Psychiatric Facilities.

Data Analysis and Trends for Northern Virginia

A. Prevalence of Dual Diagnosis

The MR/MI Workgroup experienced difficulty gathering prevalence information from existing Northern Virginia CSB database sources. Data is not easily found or available; the data system is not comprehensive; and data is stored only by specific cases or for crisis incidents. As a result of these limitations, the workgroup was not able to assess prevalence data in Northern Virginia. Therefore, for planning purposes it was decided to use the following clinical assumption based upon the published professional literature to determine prevalence:

Persons with a dual diagnosis (MR/MI) can be found at all levels of mental retardation (mild, moderate, severe, profound). Estimates of the frequency of dual diagnosis vary widely in the published clinical literature; however, many professionals have adopted the estimate that 20-35% of all persons with mental retardation have a psychiatric disorder. The full range of psychopathology that

exists in the general population also can co-exist in persons who have mental retardation.

Based upon above assumption and the estimated prevalence of mental retardation from the DMHMRSAS Comprehensive State Plan 2000-2006 for HPR II (N = 16,107), the number of individuals in the Northern Virginia area with dual diagnosis is estimated to be between 3,221 to 5,637 individuals. With current population growth trends, these numbers will continue to increase and put additional strain on the system. Although the Workgroup could not access adequate data to perform an actual prevalence assessment in Northern Virginia, the information that was obtained fell within these estimated prevalence figures. For this discussion, it is also important to note that 85% of individuals with mental retardation fall within the mild range, 10% in the moderate range, 3-4% in the severe range, and 1-2% in the profound range of functioning (Diagnostic and Statistical Manual of Mental Disorders, 4th Edition/TR; DSM-IV/TR).

B. Current Cases of Dual Diagnosis

The above prevalence information can be used for overall planning purposes, however, additional information is needed to determine services currently available, service delivery gaps and other issues. While some individuals with MR/MI issues are served well, there is a general agreement and understanding among treatment professionals and provider agencies that individuals with MR/MI are underserved. It was decided that each CSB, NVMHI, NVTC, and several private providers would review a select group of individual cases currently known to their MR and MH systems. Forty-two (42) cases were reviewed and represented three (3) general categories of treatment outcome:

- (1) Individuals with excellent outcomes and success;
- (2) Individuals who did fairly well but whose outcomes could have been better given adequate or improved services; and,
- (3) Individuals who had poor outcomes and continue not to do well despite tremendous efforts.

Using these three general categories, workgroup members generated individual consumer profiles that provided a summary of services that were critical to a successful outcome, services that could have been improved, services that were lacking, and barriers to service. These services are listed below; they are NOT in order of priority.

Current Services Critical to Achieving Successful Outcomes for the Studied Cases

- Jointly shared responsibility between mental retardation (MR) and mental health (MH) services.
- Collaboration among DMHMRSAS and CSB MR and MH agencies and private providers of residential and day/vocational services.
- Flexible funding and immediate availability based upon levels of support needed rather than diagnosis.

- Intensive case management, with smaller case loads allowing the case manager to take a much more active role in helping the consumer develop and maintain everyday life skills and build natural circles of support.
- Sufficient staff resources in both residential and day/vocational locations;
 need for 1-1 staffing during crisis and during stabilization periods.
- Well-trained staff that receives specialized training in MR/MI issues.
- Development of strategies to address crisis situations, which is an integral part of an overall treatment or discharge plan.
- Frequent coordination and follow-up with residential and day/vocational placements to ensure adherence to the treatment plan and to prevent slippage and crisis.
- Suitable day placements to meet consumer needs, including vocational and non-vocational options, as well as community college life skills degree programs.
- Psychiatrist with previous knowledge and training in MR/MI issues.
- Accurate psychiatric assessment and diagnoses.
- Significant behavioral consultation hours and more hands-on than the typical behavioral consultation.
- Options for community residential placement with a full range of alternatives such as group homes, specialized foster care, 2-3 bed homes, supervised apartments, mentor roommates, Life Coach, etc.
- Family and consumer education and support groups to recognize dual diagnosis, learn more about treatments, and to offer support for dealing with challengers of a dual diagnosis.

Barriers and Service Enhancements that Would Have Increased Successful Outcomes for the Studied Cases

- Formal agreements for collaboration and jointly shared responsibility between mental retardation and mental health services from both the DMHMRSAS and CSBs.
- Prioritized review of requests/applications for waiver funding for consumers with MR/MI issues.
- DMAS staff is typically not familiar with the specialized needs and supports of the MR/MI population as compared to consumers with only mental retardation.

- Families and consumers are not aware that they can have both a diagnosis of mental retardation and mental illness and sometimes fail to recognize the signs and symptoms of mental illness.
- Financial incentives for residential private providers to keep beds available when consumers are placed out of the home for short durations during crisis.
- Specialized training and supervision in MR/MI issues for all personnel at the clinical, medical, managerial and direct services levels.
- Specialized outpatient services.
- Partial hospitalization option to avoid removing the consumer from their home and as an option to inpatient hospitalization.
- Program for Assertive Community Treatment (PACT) model specialized in MR/MI issues.
- Mobile crisis intervention teams of both clinical and direct care professionals with expertise in MR/MI issues.
- On-going dialogue between regional and local representatives of the CSBs and DMHMRSAS with private residential and day/vocational providers concerning the types of services needed.
- Frequent coordination and follow-up by CSB case management with residential and vocational placements to ensure adherence to the treatment plan and to prevent slippage and crisis episodes.
- Limited number of behavioral consultation providers with knowledge, skills and abilities with MR/MI issues.
- Limited number of psychiatrists with knowledge, skills and abilities with MR/MI issues.

Next Steps and Recommendations

While some individuals with MR/MI issues are served well, there is a general agreement and understanding among treatment professionals and provider agencies that individuals with MR/MI are underserved due to consumer complaints, excessive lengths of inpatient stay, recidivism rates at the MH hospitals, staff turnover, and overall treatment costs. Relatively few individuals with dual diagnosis need institutional-based care; but when it is needed, it should be obtained with minimum bureaucracy. The greatest needs are for community-based mental health services that provide in-home supports, partial hospitalization and crisis stabilization; and for behavioral specialists to support staff working with the MR/MI population in all environments. Community mental health services must be willing to serve people who have mental retardation, willing to work across the various environments that the person requires supports, and willing to work cooperatively with developmental or habilitation specialists. Interdisciplinary

assessment and training is needed for staff of both MR and MH agencies with recognition that one profession or service orientation does not have all the answers. Services should be based upon individual consumer needs and supports rather than disabilities, thus avoiding "problem shifting" that occurs between MR and MH agencies. Much can be accomplished through collaboration with existing community resources rather than creating new resources in response to present limitations of single MR or MH service sectors.

System Issues

(1) Families and individuals do not understand that they or their loved ones can have both a diagnosis of mental retardation and a mental illness. As a result, treatment and quality of life is compromised for the individual and the family, as they frequently get bounced between systems and face multiple barriers for getting appropriate services.

Recommendation: Develop educational materials that address various symptoms that are associated with a person who may have co-occurring diagnoses.

Recommendation: The CSB intake should be more family and consumer friendly, in that, one case manager should be assigned to help the individual and family negotiate the entire set of services that are available to the individual with MR/MI issues.

Recommendation: Provide opportunities for the families and individuals to receive education and actively participate in treatment planning when an individual is beginning to show signs of decomposition, as well as throughout the crisis period and transition back to the community.

(2) Service provision, coordination, and oversight should promote and reinforce collaboration and joint responsibility, and lead to the development of statewide, regional, and local solutions.

Recommendation: Develop Formal Memorandums of Agreements (MOA) for MR and MH offices at both the DMHMRSAS and CSB levels. The formats should include the following:

- (a) Regional model for service delivery
- (b) Community-based focus
- (c) Involvement all major stakeholders
- (d) Specified tasks and responsibilities for all parties
- (e) Services based upon individual consumer needs and supports rather than disabilities.

Recommendation: Continued administrative support from DMHMRSAS and the CSBs for the DMHMRSAS Steering Committee and the Regional MR/MI Workgroups. Hold regular meetings with documentation of issues.

(3) The data was difficult to harvest. The MR/MI Workgroup had difficulty gathering prevalence information from the Northern Virginia CSB database.

Recommendation: Revise the current database or develop system-wide database to improve the efficacy and usefulness of data collected for individuals with MR/MI, the services and supports they receive and the environment in which the supports are provided, and the manner in which costs are reimbursed.

(4) Case management services need to be enhanced. Intensive case management services were critical to positive outcomes. Case managers must have training in mental health, mental retardation, functional analysis of behaviors, psychosocial treatment, and psychotropic medications. Case managers working for individuals with MR/MI issues must have smaller caseloads and they should provide more hands-on interaction with the consumer, residential and vocational provider so as to advocate for the appropriate services to support individuals in different environments and activities throughout the day. An alternative option of intensive case management relies upon a consultative model, in which several case managers act as specialized consultants and provide technical assistance to other case managers on issues related to MR/MI.

Recommendation: The CSBs should review current case management services and develop a system of intensive case management services that would better address the needs of their MR/MI consumers.

(5) The existing range of residential options for consumers with MR/MI issues is too limited.

Recommendation: DMHMRSAS and the CSBs should collaboratively develop and fund a fuller range of residential alternatives beyond the typical group home model. Options may include specialized foster care, 2-3 bed homes, individual homes, supervised apartments, mentor roommates, etc. Involvement with local and state HUD should be a critical component of such efforts.

(6) Behavioral consultation services are currently too limited and insufficiently funded. Effective behavioral consultation is critical to positive outcomes and successful crisis resolution. However, the current waiver consultative model is not sufficient. Consumers require more direct, hands-on service from the behavior specialist for successful clinical outcomes than is currently allowed. In addition, DMAS and DMHMRSAS have frozen the development of any new behavior consultation contracts under the waiver.

Recommendation: DMHMRSAS and DMAS should establish clinical skill criteria for new behavior consultation contracts for MR/MI consumers.

Recommendation: DMHMRSAS and DMAS should review the current waiver consultative model and consider a more direct, hands-on service delivery approach for the behavior specialist working with persons who demonstrate MR/MI issues. The funding should also support on-going training for direct care and managerial staff from pre-admission throughout the crisis period.

Recommendation: Each CSB should have a behavioral consultant either on staff or as a specific consultant for MR/MI issues.

Recommendation: In order to meet the current demand and future needs, DMAS and DMHMRSAS should begin approving new behavioral consultation providers under the MR Medicaid waiver program. The lack of an approval process for additional behavioral consultants over the recent years has resulted in a significant resource shortage for service providers and creates a reliance on staff resources without sufficient expertise in the field.

Treatment

(1) Current assessment and diagnostic protocols and treatment programs are not standardized or appropriate. The co-existence of mental retardation and a psychiatric disorder can have serious effects on the person's daily functioning by interfering with educational or vocational progress, by jeopardizing residential placements, and by disrupting family and peer relationships. In short, the presence of behavioral and emotional problems can greatly reduce the quality of life of persons with mental retardation. Misdiagnosis also can result in additional stigma and inappropriate treatment (and thus poor outcomes) for the person. It is imperative, therefore, that accurate diagnosis and appropriate treatment are obtained.

Recommendation: Develop a uniform set of standards for assessment and treatment programs for persons with MR/MI. Assessment tools would be based upon levels of support needed and encompass the entire "circle of need."

(2) Individuals with MR/MI issues may also need individualized supports in specialized areas of geriatrics, forensics, and/or substance abuse. The MR/MI Workgroup has noted that like the general population, there is a large aging MR/MI population who faces the prospects of age related physical health and mental health issues (e.g., depression, senility, and dementia issues).

Recommendation: CSB case mangers and other treatment professionals need to recognize and address appropriate supports in these specialized sub-areas to ensure stability of placements.

Recommendation: Increased cooperation and shared responsibility for service provision across single service agencies (e.g., MR. MH, geriatrics, forensics, and substance abuse) will be needed to address these complex treatment issues.

Recommendation: A global assessment and treatment plan covers all service areas and interdisciplinary teams encompass all specialized areas so the person can be treated in a holistic manner.

(3) A small number of the MR/MI population will require care in an ICF/MR. The development of inpatient psychiatric ICF/MR programs should be approached cautiously and only as one small component of a larger community-based initiative involving NVTC and NVMHI.

Recommendation: The focus of care should be community-based, with a range of treatment options, including specialized outpatient services, in-home supports, partial hospitalization, crisis stabilization, and inpatient treatment.

(4) Community-based residential alternatives with adequate supports for consumers with MR/MI are very limited. The vast majority of persons with mental retardation function in the mild to moderate range of mental retardation. These consumers are best served in a small, supportive community-based residence. Placement in a State Training Center is not appropriate for several reasons: ICF/MR level of care criteria will not be met; Training Centers serve predominately persons with severe and profound mental retardation; and mental health agencies and facilities have the psychiatric and psychosocial rehabilitation services most appropriate to meet the needs of persons with mild to moderate mental retardation.

Recommendation: Persons with severe and profound mental retardation who also have mental health issues will be served in community-based options when possible. If inpatient care is needed, they will be served only in the Training Centers, not in State Mental Health Hospitals.

(5) Placement at a Mental Health Facility is appropriate for higher functioning individuals with mild and moderate mental retardation, but many persons with mental retardation do not "fit in" with the typical mental health population. At mental health facilities, some individuals with mental retardation are easily victimized and/or they frequently do not benefit from the treatment milieu. These individuals pose more serious treatment and safety issues for Training Centers who serve predominately persons with severe and profound mental retardation.

Recommendation: Persons with mild and moderate mental retardation who also have mental health issues will be served in community-based options when possible. If inpatient care is needed, they will be served only in the specialized units of the State Mental Health hospital, not in the Training Centers.

Recommendation: Some individuals may lack a mental health diagnosis and will not meet criteria for admission to a public or private Mental Health Hospitals. However, their serious behavioral challenges prohibit effective and safe treatment in their current community setting. A crisis stabilization residential program can meet this need for more intensive services until an effective treatment program can be developed.

(6) There exists an insufficient provider network of specialized outpatient services in Northern Virginia. The NVTC Regional Community Support Clinic provides specialized outpatient services but additional resources are required to provide adequate number of appointments to satisfy current demand and address future needs.

Recommendation: Provide additional targeted funding to the NVTC Regional Community Support Clinic to provide specialized outpatient services to consumers with MR/MI. In addition, provide funding to NVMHI to create and support a Regional Community Support Clinic model program based at that location.

Recommendation: On-going collaboration between NVTC and NVMHI will be essential to any specialized outpatient effort.

(7) A Partial hospitalization option does not exist in the Northern Virginia region. Partial hospitalization is less artificial than an inpatient unit, since the person spends nights and weekends in a community residence. This model can accommodate a shorter psychiatric inpatient length-of-stay by providing stepdown level of care upon discharge from an inpatient facility. Partial hospitalization can also provide an alternative to inpatient care for those patients who do not require the restrictive security of a locked environment, but who are experiencing new onset of psychiatric symptoms or acute exacerbation of chronic psychiatric conditions.

Recommendation: Create and fund a community-based specialized partial hospitalization option that can be used as both a step-up and step-down treatment location.

(8) Each CSB should have a PACT model of care. The treatment literature indicates that participation in PACT for persons with MI/MR was associated with fewer admissions, higher social functioning, greater patient satisfaction, lower symptomatology, lower cost, and shorter length of inpatient and partial hospitalization stay.

Recommendation: Create and fund a CSB PACT model specializing in MR/MI for all the Northern Virginia CSBs. Currently only Arlington and Fairfax-Fall Church CSBs have PACT teams, but none specialize in MR/MI issues.

(9) Many community residential and day/vocational providers do not have the necessary staff resources to handle crisis situations or to provide the necessary staff supports for the short-term to meet supervision needs.

Recommendation: Train current CSB-based mobile crisis intervention teams of both clinical and direct care professionals to assure expertise in MR/MI issues. Expand this training to more traditional emergency response teams, such as police and fire department.

Recommendation: Allow flexibility in staffing and funding so that staff resources can stay in the residential and day/vocational locations for enough time to provide needed stabilization.

(10) Individuals with MR/MI issues who live independently frequently miss follow-up appointments with psychiatrists and other treatment professionals. Failure to adhere to prescribed medication and other treatment plans typically result in crisis incidents and emergency room visits.

Recommendation: Develop and fund a personal support network, mentor or life coach program to assist discharged individuals in following treatment plans. Under a model developed by Sentara Health, individuals are assigned a Life Coach who assists in applying for benefits, keeping appointments, and accessing other needed services. Data collected by Sentara during the first year of a pilot program showed that persons assigned a Life Coach kept more appointments, had fewer emergency room visits, and had lower inpatient readmission rates than individuals without a Life Coach. The Arc of Northern Virginia has a Personal Support Network program that provides a similar set of services.

Education and Training

(1) Cross training in MR and MH issues are needed for both service agencies in order for collaboration and joint responsibility to occur. This training is also necessary to develop MH service expertise among MR personnel and MR service expertise among MH personnel who have enduring or recurring contact with persons with MR/MI issues.

Recommendation: In order to develop the "next generation" of MR/MI direct care professionals, DMHMRSAS should develop a Commonwealth of Virginia Curriculum in Mental Retardation program. In a joint venture with the Virginia community colleges and universities, DMRMRSAS should provide funds and programmatic support to develop: a) training on mental retardation at the undergraduate level for college students; and b) a post-graduate training program for individuals interested in developing supervisory skills necessary to provide quality services to individuals with MR/MI.

Recommendation: Cross training of MR and MH personnel at the clinical, medical, managerial and direct services levels is needed.

Recommendation: Develop uniform system-wide training for State Mental Heath Hospital psychiatric staff on assessment, evaluation, and treatment of MR/MI issues.

Recommendation: Develop uniform system-wide training for State Training Center psychiatric staff on assessment, evaluation, and treatment of MR/MI issues.

Recommendation: DMHMRSAS should sponsor and provide funds for a series of Continuing Education presentations on MR/MI issues based upon statewide and regional priorities for training.

Recommendation: DMHMRSAS should support and provide funding for a Best Practices Conference to obtain information from outside Virginia about state-of-the-art treatment and service delivery models.

Recommendation: The Northern Virginia MR/MI Workgroup will develop topics of regional interest for the State-sponsored Best Practices Conference.

(2) The Northern Virginia area does not have sufficient psychiatrists with MR/MI treatment experience. Accurate assessment and diagnosis is critical to positive treatment outcome.

Recommendation: Develop a continuing education program for currently practicing psychiatrists who are interested in acquiring new skills necessary to provide expert services to individuals with MR/MI.

Recommendation: In order to develop the "next generation" of MR/MI psychiatrists, DMHMRSAS should develop a Commonwealth of Virginia Fellowship in Mental Retardation program. In a joint venture with the three (3) Virginia medical schools, DMRMRSAS should provide funds and programmatic support to develop: a) additional training on mental retardation at the required curriculum level for all medical school students; and b) a post-graduate training program for psychiatrists who are interested in acquiring skills necessary to provide expert services to individuals with MR/MI.

(3) Education and training efforts in the public sector should be widespread in order to develop and provide awareness of MR/MI issues, individual needs and service delivery options.

Recommendation: Provide and education and training within the Public School Special Education apparatus (both administrators and teachers). This will aid

early identification and treatment efforts and possibly prevent later challenging problems when the individual has grown physically.

Recommendation: Provide education and training to family members because they need to understand treatment issues and service options in order to advocate for needed services and supports.

Funding Issues

(1) Department of Medical Assistance Services (DMAS) staff are typically not familiar with the specialized needs and supports of the MR/MI population as compared to consumers with only mental retardation. This lack of knowledge and training results in excess red tape, delays the funding of necessary supports and services, and prevents the funding of some needed supports.

Recommendation: Representatives of the CSBs and DMHMRSAS should work with DMAS to educate them about the special needs of this population. DMAS should consider establishing a specialized MR/MI utilization review team who could review service and funding requests and then issue a recommendation to approve or deny services.

Recommendation: Prioritize review of requests/application for Waiver funding. DMAS should assign specific person(s) with expertise in the special needs and supports of MR/MI population. This DMAS group would conduct cooperative reviews with CSBs of requests for services and supports submitted by the CSB case manager. This would promote coordination of services based upon information from specialists with intimate knowledge of the individual.

(2) Legislative support for funding proposals and reinvestment initiatives will be critical to success.

Recommendation: Representatives of the CSBs, DMHMRSAS, and DMAS work with Legislators to educate them about the special needs of this population. Knowledge of MR/MI issues will aid Legislative support of crucial funding proposals and potential appropriation of State funds.

(3) Flexibility of funding and immediate availability of funding was identified as crucial to successful outcomes. Current funding mechanisms are not flexible and a delay in availability of funds has created gaps in service and supports needed for crisis management and stabilization.

Recommendation: Funding should be based upon levels of support needed rather than on diagnoses or service area.

Recommendation: Increased Medicaid Waiver slots for individuals with MR/MI issues are needed to address the large numbers of individuals statewide who have urgent needs, yet who remain on waiting lists for services until they are in crises. In addition, there is a need to identify funding for the growing number of individuals with MR/MI statewide who are waiting for services but who do not meet eligibility requirements for Medicaid waiver services.

Recommendation: Develop flexible specialized programs and services to meet the training and treatment needs of MR/MI persons in residential and day/vocational placements.

Recommendation: On-going dialogue between regional and local representatives of the CSBs and DMHMRSAS with private residential and vocational providers concerning the types of services and supports needed.

Recommendation: Funding should address the actual costs associated with services and staff supports the individual truly needs to maintain stability in his current environment and at the same time, affording protection to other individuals. Medicaid funding must be flexible rather than static to address specialized needs for support and ensure stability of placement.

Recommendation: Higher reimbursement rates for "complex" psychiatric outpatient visits and the recognition that the majority of services (particularly psychopharmacological services) to individuals with MR/MI qualify for the higher rate.

Recommendation: DMHMRSAS and the CSBs to develop financial incentives for residential private providers to create new beds and to keep beds available when consumers are placed out of the home for short durations during crisis.

(4) Since the start of Medicaid Waiver services in Virginia in 1990, there have been no regular rate increases to adjust for inflation, and there is no rate differential to adjust for the demonstrated higher cost of providing services in Northern Virginia, unlike other Medicaid reimbursable programs.

Recommendation: DMAS and DMHMRSAS should consider addressing the need for a rate increase for both residential and day/vocational placement Medicaid waiver providers that reflect the actual costs of services.

Recommendation: A rate differential to adjust for the higher cost of providing services in Northern Virginia programs should be considered also.

The Northern Virginia Regional MR/MI Workgroup appreciates the opportunity to present these findings and suggested recommendations for consideration.

Attachment 1: Definition for Dual Diagnosis (MR/MI and MI/MR)

Most broadly ... Dual Diagnosis is *the co-existence of the manifestations of both mental retardation and mental illness"* (from the National Association for the Dually Diagnosed (NADD), 2003).

The Diagnostic and Statistical Manual of Mental Disorders, 4th Edition/TR (DSM-IV/TR) defines Mental Retardation by three criteria:

- Below average intellectual functioning, as measured by an intelligence quotient (IQ) obtained by an individual assessment (usually a score of 70 or below):
- Onset before age 18 years; and
- Concurrent deficits or impairments in adaptive functioning.

DSM-IV/TR also specifies different levels of severity - Mild, Moderate, Severe and Profound.

However, there are definitional differences between the DSM-IV/TR and the new American Association on Mental Retardation (AAMR) Definition, Classification and Systems of Supports Manual (2002).

- AAMR uses the IQ score of 70-75 as the marker for below average intellectual functioning, in order to take into account measurement errors (+/- 5 points) in testing;
- AAMR classifies persons with mental retardation based on "Patterns and Intensity of Supports Needed". The levels are Intermittent, Limited, Extensive and Pervasive.
- AAMR does not specify the four (4) levels of severity used by the DSM-IV/TR.

<u>Mental Illnesses</u> are "severe disturbances in behavior, mood, thought processes and/or interpersonal relationships" (DSM-IV/TR). Common types include: Affective Disorders, Psychotic Disorders, Depression, Personality Disorders, Anxiety Disorders, and others (per DSM-IV/TR).

[Adapted from the website of National Association for the Dually Diagnosed (NADD, www.thenadd.org)]

<u>Based on the most significant factor contributing to functional impairment, Dual</u> Diagnosis includes two major Sub-Groups:

MI/MR: Persons for whom a serious mental illness is the most significant factor
in their functioning and who has either mild or moderate mental retardation.
Problems in daily living are primarily the result of the mental illness; or
manifestations of the mental illness are creating the most difficulty in successful
community living. Although some cognitive impairment exists, they have limited

impact as compared to the mental illness. Example: a person with Schizophrenia and Mild MR.

 MR/MI: Persons for whom mental retardation is the primary basis for problems in daily living. Usually the level of mental retardation is severe or profound, and level of supports needed is extensive and pervasive. In general, the developmental delay was an issue for supports prior to development of a serious mental illness. Example: a person with Severe MR and Major Depression.

Differential diagnosis between these two groups is critical in determining the most appropriate placement, supports and therapeutic interventions.